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# Official Report of Debates (Hansard)

Wednesday 9 February 1994

# Journal des débats (Hansard)

Mercredi 9 février 1994

## Standing committee on social development

## Comité permanent des affaires sociales

Tobacco Control Act, 1993

Loi de 1993 sur la réglementation  
de l'usage du tabac



Chair: Charles Beer  
Clerk: Doug Arnott

Président : Charles Beer  
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## STANDING COMMITTEE ON SOCIAL DEVELOPMENT

Wednesday 9 February 1994

The committee met at 1003 in the Travelway Inn, Sudbury.

## TOBACCO CONTROL ACT, 1993

LOI DE 1993 SUR LA RÉGLEMENTATION  
DE L'USAGE DU TABAC

Consideration of Bill 119, An Act to prevent the Provision of Tobacco to Young Persons and to Regulate its Sale and Use by Others / Projet de loi 119, Loi visant à empêcher la fourniture de tabac aux jeunes et à en réglementer la vente et l'usage par les autres.

GLEN McDONALD

**The Vice-Chair (Mr Ron Eddy):** Welcome, ladies and gentlemen. Good morning. We'll commence with the first presentation, to be made by a representative of the Pharma Plus Drugmart in Sudbury. Mr McDonald, you are allotted 15 minutes, and we hope that there will be time for a few questions following your presentation.

**Mr Glen McDonald:** On behalf of Sudburians, I'd like to welcome the committee to Sudbury on this cold morning. I'd accuse you of bringing this weather with you from southern Ontario, but I'm sure you all know better.

Thank you for the opportunity to present to you this morning. My name is Glen McDonald. I've been a pharmacist for 23 years and work at the Pharma Plus Drugmart in the New Sudbury Centre. I was born and raised in the Sudbury area and have lived here all my life, other than the four years that I went to university in Toronto.

I think that the stated intent of Bill 119 is good and I support it in the main, especially the raising of the legal age from 18 to 19 and the reduction in the number of vending machines.

I don't approve of smoking. My mother, who was a heavy smoker, died of lung cancer at the age of 41, and my father died last November from pneumonia complicated by emphysema which was also the result of many years of smoking. I know 13,000 Ontarians die annually as the result of smoking.

I'm here before you because I oppose paragraph 4(2)8, which prohibits the sale of tobacco products in pharmacies. I have two reasons for this opposition: first of all, the impact on jobs in pharmacy, and secondly, because I don't think it will be effective.

First, the jobs issue. Our pharmacy employs 21 people and is open for business 74 hours per week. We have 5,000 square feet of retail space, so we can't rely solely on prescription and over-the-counter sales. We therefore sell a wide variety of items, including cosmetics, health and beauty aids and magazines. In fact, we have even installed a post office.

The Ontario government recently cut our dispensing fee and we are under pressure from third-party carriers and mail-order pharmacy. Add to this the possible loss of

tobacco sales and companion sales and some jobs will be lost.

Two of our Pharma Plus Drugmarts have closed here in Sudbury in the last few years, including our downtown location, which closed just last fall. Every pharmacy cannot be a health care facility only. There are only so many patient aids that can be sold.

My second reason for opposing section 4(2)8 was because I don't think this ban will work. Banning tobacco sales in pharmacies makes no sense if the spirit of the bill is to deter people under 19 from buying cigarettes. A study by the Lindquist Avey group showed that pharmacies were the most diligent at enforcing the ban on tobacco sales to minors. This was corroborated by one of the young smokers who appeared before you yesterday.

It is difficult to understand how redirecting the sale of tobacco from pharmacies to corner stores will resolve anything. It seems to be a cosmetic approach. If all of us are truly serious about addressing this costly health care crisis, then we would make tobacco a controlled or a restricted sale item, even with the inherent loss of government revenues.

There are ethical issues involved as well. There is the question of whether we can justify having products for health care at one end of the pharmacy and tobacco products at the other. I don't think customers have a problem with this. As a pharmacist, I am not directly involved in the sale of the tobacco products. The customers seem able to separate the professional area of the pharmacy from the front shop where the tobacco products are sold.

Many customers are not shy. They are quick to point out things that upset them: a price that's too high, a sale item that's out of stock or a product that they feel is inferior. But in my 23 years in pharmacy, I've not had one person say that they don't think we should be selling tobacco products.

The ethical dilemma is real but it has to be weighed against the practical reality. Last week, three students from this year's graduating class in pharmacy appeared before the committee. The high ideals they showed are commendable. When one of the three was asked how pharmacists should replace the revenues lost by elimination of tobacco, she said they shouldn't worry about recovering the lost sales, but rather continue counselling people on their medications. Idealistic, yes, but the reality is that these graduates may not have jobs to go to.

A local MPP was quoted last week saying pharmacists can't have their cake and eat it too, meaning that they can't expect to be considered health care professionals and sell tobacco. Also last week, a doctor from British Columbia told the committee that if pharmacists want to be considered as health care professionals, they should not sell tobacco products. He also said that young people associate tobacco in pharmacies with it being okay to



smoke. This has not been borne out by any young people who I've spoken to or by those who appeared before the committee.

Maybe to be considered a health care professional, a doctor or pharmacist should rather not smoke himself; that is, lead by example. I think this would be more likely to influence any young person we come in contact with.

1010

Finally, after 23 years as a retail pharmacist, I find it hard to feel like a scoundrel for working in a pharmacy that sells tobacco. Governments are elected to serve the people. Perhaps this government needs to ask itself if by banning tobacco sales in pharmacies it is doing what the public wants, or if it is even in their best interests.

**Mr Jim Wilson (Simcoe West):** Thank you, sir, for your presentation. Much of what you've said has been reiterated by a number of your colleagues who appeared before the committee. You did say something, though, that disturbs me.

This is the first time we've been outside of Toronto so it's important to get the—

**Mrs Dianne Cunningham (London North):** Other than London.

**Mr Jim Wilson:** Other than London, Ontario.

**Mr McDonald:** It's part of Toronto.

**Mr Jim Wilson:** To me it's all the same.

**Mrs Cunningham:** No, don't tell me that.

**Mr Jim Wilson:** I come from Toronto, so it all appears to be the same, but none the less, I guess we've just lost all the votes in southwestern Ontario.

None the less, I think in my part of the province—I'm north of Toronto, more of a small-town, rural area. Many of the pharmacists there, even the ones who have voluntarily removed cigarettes or tobacco products from their shelves, still oppose the ban on a business principle and they tell me they're retailers, and you've made that point. But you did say it might be difficult to replace the sales lost to tobacco products and the companion sales, which is the main point.

Do you want to expand on that? Because I think you said not everybody can get into prostheses or whatever other health care lines. I have the same problem. The town of Alliston has three or four pharmacies. They all can't just move into video sales or something like that to replace the tobacco products.

**Mr McDonald:** I think when I spoke about the high ideals of the graduating students and when I watched that part of the proceedings, I could put myself in the same position when I was graduating. I probably would have felt exactly the same way. Everybody would like to come out and work in an environment where all you do is dispense prescriptions, counsel people, maybe help them a little bit with cough and cold needs, vitamins, that kind of thing, and not even have to bother with the rest of the cosmetics and magazines and things that I mentioned.

But when you have a retail area, like I said, of 5,000 square feet, it just doesn't work. We have rents to pay. I'm just talking about my particular situation. We're in a

mall and there's a high fixed cost, so you have to diversify. Historically, we've sold tobacco and it's brought in a fair amount of revenue. Those sales would be hard to replace. What I meant by not everybody can sell is there are so many bedpans that can be sold, so if every single pharmacy all of a sudden brings all these items in, walkers and bedpans and things, there's not going to be any more sold in the city, so it's not going to be really be that much of a boon to your business to replace the lost sales.

**Mr Dalton McGuinty (Ottawa South):** Thank you for your presentation, Mr McDonald. I happen to agree that the provision in the bill which bans tobacco sales in pharmacies is unfair and I don't think it will help achieve the stated objective of the bill, which is primarily to reduce smoking in kids.

I think when you weigh that against the broader message that we're sending—you can now smoke when you're 19, right? So when you're an adult, when you're grown up, then you can smoke and it's still a legal product. So I think in the face of that, it's really not going to make much of a difference whether we ban it in pharmacies or not. I guess if we wanted to be really dramatic, we'd ban it everywhere. That would be a powerful message, but obviously for a number of reasons we can't do that.

But you talked about, and somebody else has mentioned this as well—I think a number of presenters have—making tobacco products controlled or restricted. What does that mean and what would the practical implications be?

**Mr McDonald:** When you really think about it, when products become more controlled, they tend to go into pharmacies rather than out. And the more controlled they become, the closer they get to my area or even in behind the counter with us, because they count on us then to counsel people on the pros and cons of taking particular products. Schedule C is what comes to mind. We're expected to participate in the sale of every schedule C item.

**Mr McGuinty:** Give me an example, something that I would know about that's a schedule C item.

**Mr McDonald:** Ibuprofen.

**Mr McGuinty:** Is that the pain reliever?

**Mr McDonald:** Motrin. I'm giving you the chemical name. Nicorette gum is another, seeing we're talking about smoking. The other thought—I think it's been mentioned a few times—having instead of an LCBO, a TCBO outlet maybe makes sense if you really want to control it.

**Mr Jim Wiseman (Durham West):** I guess, from my perspective, I look at what should be the ultimate goal, which really is to eliminate cigarettes from everywhere. Eventually, that would mean they would be eliminated from drugstores and so on. The goal of this legislation is to get the message out to young people that smoking cigarettes is going to really do harm to their lives and to their lifestyle.

Since you're a thoughtful man and I found your presentation thoughtful, I'd like to ask you if you could



give the committee some idea of what we could really put into this bill that would be different, that would really have some meaning in terms of making it more difficult for young people to get cigarettes?

**Mr McDonald:** I think one of the key things is, when you think of illegal drugs—like marijuana was a big drug years ago and it was illegal, but I don't think kids had any trouble getting it in the school system. With all you hear about contraband cigarettes coming in, I'm sure they're all over in the school system. Whether you ban it from all legal retail outlets, I think you still have to get tough at the other end, the illegal aspect of it.

**The Vice-Chair:** Thank you for your presentation.

#### YMCA YOUTH EMPLOYMENT SERVICES

**Ms Jody-Lyn Joki:** Good morning. On behalf of the YMCA Youth Employment Services, I'd like to welcome this committee to Sudbury. My name is Jody-Lyn Joki. I am a youth representative for the Sudbury region at the YMCA employment services. This service provides unemployed youth with training to successfully complete their job search independently. We also provide on-the-job training for those who need it and we help youth attain their grade 12 diploma.

I am currently working on a project called youth policy directions, which is a provincial project that provides youth with a voice when it comes to policy-making decisions that affect them. Because Bill 119 is a policy that affects youth, I appreciate this opportunity to express my thoughts regarding this proposal.

Promotion, peer pressure and accessibility are the main reasons why so many young persons start up smoking and continue. On any given day, our exposure to the promotion of cigarettes is almost continuous. For example, while I was on my way to work the other day, I stopped to fuel my car. When I walked in to pay the clerk, there on the counter was a variety of different brands of cigarettes. Next, I stopped at a convenience store to pick up a juice and an issue of *Cosmopolitan*. As I searched my wallet for change, I looked up and once again I was confronted with racks of cigarettes.

Later on, during my midmorning break, I was leafing through my *Cosmo* and I came across an appealing ad for Virginia Slims cigarettes. The ad portrayed a tall and slender young lady with a clear complexion and perfect white teeth. She sat there with a red leather jacket on, her legs wrapped around a street bike, caressing a smoke between her fingers. The message is: If you smoke Virginia Slims, you just might look and feel as beautiful as her. How misleading, I thought.

However, in the corner of the ad in black and white was a Surgeon General's warning: "Quitting smoking now reduces serious risks to your health." But what could this warning mean to young people who are feeling healthy and think they are fitting the image of the beautiful people portrayed in the cigarette ads? Judging by how many of them start and continue smoking, the warning does not mean much to them.

#### 1020

Finally, on my way home from work, I stopped to pick up a few items at the grocery store. As I walked in—you

guessed it—more cigarettes. Cigarettes are effectively advertised and they are also strategically located in stores so that they are being well promoted. Not only does their location in the store serve as promotion, it also increases their accessibility. At this point, cigarettes are accessible to high-school-age youth. Bill 119 would restrict smoking to people aged 19 and over. That would require that people must produce identification in order to purchase cigarettes, just like alcohol purchases.

Some people may argue that photo ID will not prevent all minors from obtaining cigarettes. This is true; there will be irresponsible people who will put cigarettes into the hands of youth. Also, some people under 19 may look older than they appear and may not be asked to produce ID when purchasing cigarettes. This situation occurs sometimes with alcohol purchases, but most youth under 19 are refused because they cannot produce the proper ID.

Having to produce a driver's licence or photo identification would only be a problem for those not old enough to obtain the proper ID. The penalties provided by Bill 119 for those establishments that sell cigarettes to minors serve as a deterrent, just like speeding limits on highways. Not everyone follows them, but most people drive at reasonable speeds. Therefore, laws are enforced and they serve as a deterrent.

The accessibility to cigarettes that vending machines provide for youth can hardly be argued. A vending machine cannot ask for ID. Cigarette vending machines practically put the smokes into the hands of youth. The removal of cigarette vending machines is addressed in Bill 119.

At this point, cigarettes are easily accessible to high-school-age youth. When I was entering high school, I was 13 years old and I looked up to the 18-year-old seniors as to how I should dress and how I should act. It is no different for smoking. To decide whether or not to smoke, a 13-year-old freshman looks up to seniors as role models. Although 18-year-olds are entering into adulthood, they are still intermingling with people who are essentially still children.

Being at age 20, I still have clear memories of the pressure of trying to be like the seniors. Freshmen look up to them. They are cool. Freshmen are still growing and developing and they are not as mature as their senior counterparts. One way they can become like them and join them that is within their grasp is to smoke with them.

Adolescence is a very difficult and confusing time for young people. Appearing or feeling older has the effect of releasing the youth from feelings of awkwardness. The youth may reason that having a cigarette hanging out of their mouth will accomplish this. This occurs daily within the smoking compounds of our high schools today. Bill 119 will not only restrict smoking to people beyond high school years, but it will also keep smoking off high school property.

All of us are aware of the huge effect that peer pressure has on people today, but peer pressure is even worse for teenagers who are trying to conform to an image of what is cool and acceptable. Most of my decisions as to



my direction in life were made during my high school years. This is a time when most high school youth decide on what career they want to pursue, where they want to work or whether they want to go on to post-secondary education.

These are very important decisions for a person who has so little experience, but they are ones that will dramatically affect the rest of their lives. It is also at this time that people make the decision of whether or not to smoke. If the young person decides to smoke, he or she is being initiated into what may result in a lifetime of addiction, poor health and certain financial strains due to this decision.

Everyone begins to smoke because of peer pressure. No one ever takes a first drag of a cigarette and says, "Oh, boy, doesn't this taste good," because at first cigarette smoking is noxious to anyone. Cigarette smoke is something a person must train their body to accept and to crave. Keeping cigarettes out of the schools will help alleviate some of the peer pressure that results in young people starting to smoke.

Smoking is an addiction and no addiction has positive results for the short term or long term for the addict. It is commendable that the government is putting forth an initiative that would result in fewer people becoming addicted to cigarettes. It would accomplish this by reducing accessibility of cigarettes to the ages where this addiction usually begins. By passing Bill 119 it would accomplish those objectives and for those who do not take up smoking because of Bill 119 there is a better chance that they will live a healthier life, free from the addiction of cigarettes.

**Mr McGuinty:** Jody-Lyn Joki, thank you very much for a very articulate presentation, I think, of some of the special influences to which young people are susceptible. I thought you presented that very well.

We had an interesting presentation yesterday from a group of committed young people, smokers, who described for us some of the difficulties they had in kicking the habit and why they started and their great reluctance to give up the habit, notwithstanding what happens in terms of us passing new laws.

There's an idea that has been kicked around here and if it is met with great approval, I'll lay claim to property ownership; if it flops, then I'll give the benefit here to my Conservative colleagues. That's this idea—I think it's a good idea, in fact—that deals with assigning some responsibility to our young people when it comes to cigarettes. By that, I mean imposing some kind of a penalty in the same way we do for young people if they're caught buying liquor underage or if they're caught in possession of liquor underage.

If I'm a young person, I'm out in the field and I'm having a drink, there's a law against that, but if I'm smoking, there's no law against that. I think the law sends a powerful message to young people and maybe we're missing the opportunity by not including such a provision in this bill. What do you think?

**Ms Joki:** It is something I have considered and I have discussed with other people and I do think it would deter

a lot of youth from starting to smoke. It won't prevent all youth from smoking. As I mentioned in my presentation, they'll always find a way. There will always be people who start to drink, but it is something that deters a lot of youth from going ahead and drinking alcohol and I think it would be effective. If this bill is passed and those under 19 aren't to purchase cigarettes, then some of the responsibility should be put on the one who attempts to buy the cigarettes and who is smoking.

**Mr Jim Wilson:** Thank you very much for your presentation. I thought it was excellent. As you know, all three political parties agree on this legislation and voted for it on second reading in the House. I think where we bog down from time to time is the clause that deals with the banning of sale of tobacco products in pharmacies. There are some differences among the government and the opposition with respect to that issue, and vending machines, because I just wanted to take the opportunity at the beginning of these hearings to clear that up. Certainly, my party agrees we should ban it in vending machines for the most part, but we should also compensate those vending machine owners whom we might be putting out of business.

You did mention in your remarks—and I want to make sure, just following what Mr McGuinty was saying, that we not leave the impression out there that this bill is anything dramatically different than what the current law is. It simply increases the age to 19, puts heavier penalties on retailers or people who sell cigarettes or furnish cigarettes to people below the age of 19. That's not any different than the current model we've been looking at, which is 18, with penalties on retailers.

I think the big thing is an addition to putting some onus on the young people themselves, that is, in one state where they've brought in a licensing model, they also fined the young people \$25 and you have to go down to the police station and pay the \$25. You've answered that question.

It was interesting yesterday when we had a group of smokers. I got the impression from most of them, I think four out of five of them basically told us nothing would deter them from smoking, that it was just something young people have to go through and it's a trial-and-error thing. Do you have friends who smoke and, if so, what's their attitude towards what we should be doing? What would make them stop smoking, do you think?

**1030**

**Ms Joki:** Yes, I do have friends who smoke. I'm not quite sure. I can't give you an exact answer what would deter them. As I mentioned in my presentation, there's a high level of accessibility to cigarettes for youth. Everywhere they go they're bumping into cigarettes. It's practically embedded into their lives. It's promoted on television, it's promoted in magazines when it comes to advertising, any store they walk into, and even certain department stores now have little refreshment areas where they sell cigarettes. So if the government decided to go further with Bill 119, it probably would be a good idea to think of decreasing accessibility in retail establishments when it comes to cigarettes. Otherwise, like those youth you mentioned yesterday, if they want to smoke, they



will find a way to smoke, and if it is accessible, they will get to it.

**Mr Jim Wilson:** Good answer.

**Mr Anthony Perruzza (Downsview):** First of all, thank you very much for appearing before the committee. It's tough enough to appear before groups like this and I think it's even more courageous when you don't necessarily have a financial interest or a personal stake in what we're dealing with. It's not often you find people who don't have a personal stake in what we're dealing with who'll come and appear before the committee. It's really easy when there's a financial interest to motivate yourself and say, "I've got to get out there and give those people a piece of my mind, because it's going to impact on my livelihood." You obviously can make the lifestyle decisions that are good for you and you can choose to smoke or not to smoke. I suspect you'll choose not to smoke and I think that's the wise way to go.

I just want to get your feedback, because I think you're going to hear a lot of bantering that goes around the table on how everybody agrees and doesn't agree, but we obviously all make decisions on how to pursue this particular issue in different ways. I don't necessarily agree that cutting taxes on cigarettes or bringing down the price of cigarettes is a good thing, in that if you make them more affordable, I think more young people are apt to reach for a pack.

We had an expert appear before this committee the other day who suggested that in a person's lifetime we give over three million viewings of cigarettes and cigarette packages, green ones, red ones, white ones, blue ones, striped ones, all these really colourful, really appealing, really sexy packages of cigarettes. If you place them in places where you have it in your own mind, and especially in a pharmacy where you go in and you say, "This is a place where I can get medication to get healthy and be well," and at the same time you find this sexy, chic pack of cigarettes which you've viewed a million times already in your life and you associate it with a particular lifestyle that's very appealing, I don't think that's necessarily a good thing.

I just basically wanted to get some feedback from you, because the Conservatives don't believe that we should take cigarettes out of drug stores and that kind of thing, and the Liberals obviously now believe that cigarette taxes should be reduced.

**The Vice-Chair:** Mr Perruzza, your question please.

**Mr Perruzza:** That's my question. I just wanted to get some feedback on these two things.

**Ms Joki:** Regarding cigarette packaging?

**Mr Perruzza:** Cigarette packaging and how taxes would impact on young people's ability to purchase them, and whether that's a good thing or not.

**Ms Joki:** First I'd like to address the cigarette packaging. You did mention it earlier on in your question. I have read quite a bit of information regarding it and I do agree that is something that makes it more attractive to young people, the packaging. Like I mentioned, regarding the Cosmopolitan advertising and smoking, when a youth sees something like that and they're young and they don't

have the maturity of an adult, that is very attractive to them. Some of the cigarette packages, and I'm sure you've heard this before and you'll probably hear it again, do look similar to perfume bottle boxes. When they are portrayed in that sort of fashion, it is almost encouraging the youth to take up smoking.

When it comes to taxes, I'm really not sure. I've never gone ahead and purchased a package of cigarettes before.

**The Vice-Chair:** Congratulations.

**Ms Joki:** Thank you. But I do think by decreasing taxes, it will make it more accessible to youth to purchase them.

**The Vice-Chair:** Thank you for your response and for your presentation.

CANADIAN CANCER SOCIETY,  
ONTARIO NORTHEAST REGION

**Mrs Helen Ghent:** My name is Helen Ghent. For the last two years I have been president of the Ontario division of the Canadian Cancer Society, an organization of volunteers who have no vested interest other than the health and welfare of Canadians with regard to prevention and cure of a disease that is taking hundreds of thousands of lives, many of which are directly related to tobacco.

I appreciate the opportunity to speak to you, particularly because I think it's important that you listen to the public as well as recognize the fact that you should be listening to research.

We're particularly delighted with the present government's stand. We congratulate Ruth Grier on her continued commitment to her targeted tobacco-reduction figures, because we believe that those should be the issue, and also Floyd Laughren, who under tremendous fiscal constraint, is really trying hard to hold the line. The issue of roll-back of tobacco taxes is devastating frankly to the whole issue of prevention.

The tragedy is, we're already behind the eight ball, because the damage from tobacco consumption is cumulative. So we already know that for the next 20 years, we've got big, big problems in terms of health care. If we don't do something pretty quickly to stop the addiction of 3,000 victims every month, we're going to be in a position that's horrendous. Therefore the Ontario tobacco act is critical, frankly.

I think the important thing is, I look around the table here and realize that we're talking about a group of people who have the potential to become addicts who think 30 is old. They don't care about the messages, because they're invulnerable. They're young. Don't you remember? I remember the first cigarette at eight, and I forced my four-year-old brother to have one so he wouldn't tell my parents. I think we have to understand the psychology behind this.

We feel it's particularly important for the government and all parties, because this is an opportunity to make a very strong statement to those people who have elected you to take responsibility for the health of this province and to follow the pursuit of health, not at the expense of personal or corporate profit.

I think it's important for you to recognize how we as an organization work. I am today representing the

northeast region. That's a horrendously large area. It covers Cochrane, Timiskaming, Sudbury, Algoma, Parry Sound and Nipissing. There are hundreds of volunteers who every year bring services and programs to 5,000 cancer patients: supplementary services, transportation to treatment and emotional support. Apart from that, we have a lot of volunteers who are bringing health messages about how to reduce your cancer risk. What good is it when we have no backing, we have no legislative clout? I think it's critical that you understand that.

This disease affects not just the victim himself, but it affects families, friends and communities. It's at tremendous public and private cost in pain and agony and suffering. These volunteers who sit with these patients, who drive them, they know that pain and agony, and they know that with the information we have today about tobacco, a lot of this could be prevented.

#### 1040

I think it's important also to realize that the Canadian Cancer Society, in the time it has been raising funds for cancer research, has provided \$1 billion to the National Cancer Institute of Canada. Not one penny has come from the government. Every single cent has come from knocking on doors and asking the public for money. That money has been entrusted to us to find the answer to this disease. The interesting thing is, the answers have been forthcoming, but they haven't been the answers that people necessarily want to hear. The most significant of all is that tobacco products cause cancer.

What is really significant here is that this product kills when used as intended. It has no other use. If it were discovered today, it wouldn't be allowed to exist. It would be in the hazardous substances act. Even the United States, which is behind in taxation, has classified environmental tobacco smoke as a carcinogen. Canada better wake up and do the same thing.

Putting a human face on statistics is important. Three things have happened in statistics that I think are relevant. Last year 10% of grade 7s in Ontario were smokers, a 50% increase since 1991. That's pretty significant. While we're sitting here today and you're deliberating, every 40 minutes a person will die from tobacco-related disease, five times the number of AIDS, suicide and traffic accidents combined. We get all the press and all the ads about AIDS. It's insignificant compared to something that we can do something about. Tobacco is the cause of 30% of all cancers and 85% of lung cancers; pretty significant.

As it stands, I think Bill 119 makes a clear health message. It reinforces the scientific evidence that tobacco products cause disease. It allows for personal choice at the age of consent. It restricts access to children through controlled outlets. By the pharmacy ban, and I think this one's absolutely critical, it underscores the difference between tobacco and other legal products. It provides for measures that will deter and penalize offenders.

It's really important that, at the same time, we want to ensure that the intent of the legislation is actually met in interpretation and enforcement, because that's been the weak link with anything that exists today. There is no enforcement and there's really no regard for the law. We

want to make sure that there's no question about the government's very honest effort to prevent illness and premature death.

If I were to look at the specifics of the recommendations, to sell tobacco in pharmacies is in opposition to what a pharmacist stands for in terms of public trust and in terms of selling products that enhance one's health. There is absolutely no use for tobacco in the healthy life of a person in any way, shape or form.

I think the other thing that Jody-Lyn very definitely talked about was the vulnerability of young people to peer pressure, advertising and logos. Frankly, a tobacco package is an accessory, and therefore plain packaging is really an issue that needs to be addressed. It has nothing to do with adults. It just makes it unattractive to children. For your information, the cancer society in Ontario invested in some research this year with regard to plain packs. The results of that have just been released and will be available to you if you wish.

The other issue of course is vending machines. A child doesn't even have to be tall enough to reach a counter to have access to a vending machine, so it obviously has to go.

With regard to the kiddie packs, I find that reprehensible, because it just shows the targeting methods of an unscrupulous industry that knows that adults are either addicted or will have enough sense not to smoke, where children are the targeted audience and they don't have the maturity to deal with the issue.

I'd like to conclude my remarks with a personal statement. I've been involved with this organization a long time and my particular area of interest is education. I was a smoker when I started doing education for the cancer society in—well, it was years ago, but it was in 1971 that I stopped. The reason I stopped was that I read an article in *Progress* magazine, which is the magazine of the National Cancer Institute of Canada. Dr Tony Miller, who you probably know is a well-known cancer epidemiologist, wrote a scathing attack in which he said that any Canadian Cancer Society volunteer who was involved with education and who smoked had a choice: They either stopped smoking or they got out of education, because they were doing more harm than good.

Children, for a number of years, look to their peers, their parents, their teachers, role models on television and in their community, and they believe everything that's told to them. What those people say is, "Don't smoke, don't drink, don't take drugs." One day they wake up and they look at these very people who smoke and drink and take drugs. So obviously the message is, "It's okay."

With the help of this legislation, our elected representatives can make a strong statement. They can end the hypocrisy of pharmacies selling a product that has only a deleterious effect on health. They can remove the control that tobacco manufacturers try to exert over vulnerable consumers through sponsorship advertising and package design. They can ensure that people who circumvent the current law see no opportunity to do so with the new legislation.

Then, with the help of this legislation, the things that



the other health charities, including the cancer society, do which are bringing health promotion and cessation programs to the public can be done with more meaningful results.

I really pray that you, as a group, bring back the right messages to the House and that you have the stamina and the guts, frankly, to deal with this in a very proactive way to protect the health of the children in this province. Down the line, we'll have a healthy place in which to live. I do believe the bill needs to be strengthened and that there have to be real teeth in it, but thank God we live in this province, because it's nice to see the effort that you're putting into it. I really believe you're trying to come up with the right results.

**Mr Wiseman:** I have just one very short question. The one thing you said that really concerns me is that there is this 50% increase in the number of grade 7 kids who are smoking, the 10% of them. This really concerns me, because there are no more smoking ads on TV. There's a real culture out there. Even my 4½-year-old is telling the neighbour to stop smoking. So what's going on? Why do we have this increase in smoking among grade 7 kids?

**Mrs Ghent:** I believe that when you look, there are single-cigarette sales, there are kiddie packs. There are no laws being obeyed about the age at which somebody can buy, there's no enforcement of anything, and peer pressure is still the issue. So if we don't close those loopholes, I don't think it's possible.

**Mrs Yvonne O'Neill (Ottawa-Rideau):** Thank you so much for a very enlightening presentation. You've been in the field long enough to really underline your credibility.

There are a couple of things I'd like to ask you, one of them being that you think the bill should be strengthened and I would like you to be a little more specific, because I don't think you've put any of that on record. Secondly, have you got any ideas for us about how it could be better enforced? I'm thinking of other possibilities, of fines or whatever. Maybe you would like to say a little bit about both those things.

**Mrs Ghent:** With regard to the enforcement, and I'm speaking on behalf of the cancer society, we didn't know what format that would take in terms of regulating outlets, because I think that licensing of vendors is a really key point. I think they have to understand that this is not just a candy bar or a Lotto ticket. To be able to sell tobacco, there are rules and regulations and they have to be abided by. I think that is the first thing.

The fine has to be appropriate. It has to be significant, that you revoke their licence after a first offence or second offence and put in severe monetary penalty.

**Mrs O'Neill:** So you think the municipalities should have the onus, all of them, of putting it on, or do you think it should be part of this bill?

**Mrs Ghent:** I really can't give you the answer, but I could get back to you with a position statement from the organization.

**Mrs O'Neill:** Okay. That would be very helpful.

I like that you say, "Pharmacists are persons of trust in

the community." That's a very important statement.

**Mrs Ghent:** Yes, and I find it very hard to believe that anybody's income—I know it will be affected, but I don't believe that anybody who runs any business has a right to sell everything.

1050

**Mrs O'Neill:** Can you say anything more about strengthening the bill?

**Mrs Ghent:** Again, I'd like to see vending machines abolished altogether, or else they're going to have to be behind the bar, literally, and somebody there is going to have to dispense them. Nobody gets direct access to it.

I think the vendor must have proof of identity, not assume that the person looks their age. That has to be legally strengthened.

**Mrs O'Neill:** You say something about cigarette cases.

**Mrs Ghent:** Paraphernalia, yes. That goes along with advertising and accessorizing, and I do believe that has no place. I think that is exactly the avenue and the strategy that tobacco companies will use. They are using the corporate opportunity for culture and sport, so they're getting around the advertising that way. I think it's wrong.

**The Vice-Chair:** Thank you for your presentation. It's very helpful.

LANGLEY NEAL ROBERTSON

**Mr Langley Neal Robertson:** I'm Langley Neal Robertson. I'm an independent pharmacist from Harris Guardian Drugs in North Bay. I'm speaking for myself basically, not for any group, just as a pharmacist, one who doesn't sell tobacco any more and who, 21 years ago, smoked. So there we are.

**The Vice-Chair:** We're pleased to hear from you.

**Mr Robertson:** As a preface to this presentation, I have to state that I view the introduction of selective prohibiting legislation with great reservation. My feelings have always been that the less legislation, the better. Keep it simple.

I bring this up only to emphasize that, to me, the use of legislation is the last resort and should always be invoked with extreme reluctance. This point has been reached. Please view what I'm going to present through this light and please realize that in my mind this is a necessary step towards what must be done to prevent the spread of this menace. I don't feel the word "menace" overstates the problem, but in fact understates it.

Tobacco use is the largest preventable cause of death and therefore Ontario's most important health problem. The extent of this devastation is difficult to imagine—in fact, it sounds like fiction—but consider that in the time allotted to me for this presentation possibly one Canadian has died from a smoking-related disorder. I think anything that kills a Canadian every 15 minutes is a menace. This figure is a little different from what I heard a few minutes ago, but I got it from another source.

My suspicion is that by now you will have heard almost everything I have to contribute, because I've either seen what I'm going to say in print or I've been

watching some of the proceedings and have heard, often, what I was going to say. Bear with me, please.

With that in mind, I speak in favour of Bill 119. Restriction of access to all tobacco products should be the emphasis, and to this end, the discontinuance of sales through health providers is a must: No sales in pharmacies or hospitals. The health provider selling tobacco products is the ultimate contradiction.

I should note at this point that the initiative to ban tobacco sales in pharmacies originated with the Ontario College of Pharmacists, the regulating body of the self-governing profession of pharmacy, not the government. At this point I'd like to commend the government and the opposition parties for getting it to this point; second reading, I understand.

The Canadian Pharmaceutical Association states that a pharmacist should not participate in an advertising or promotional program which might encourage misuse or abuse of drugs. So tobacco products, which in fact kill, have no place in a pharmacy.

The legal age to purchase tobacco should be increased to 19 from 18. Of course, this is beneficial since after the age of 19 it's been found that people are less likely to smoke if they haven't started. As an interesting anecdote, it has been illegal to sell tobacco products to persons under the age of 16 since 1908; however, the median age for becoming a daily smoker is 15. Overall, teenage smoking has declined, but a disturbing trend has shown up since 1991: the increasing tobacco use of grade 7s, which we just heard about a few minutes ago. I say 9.4%, but who cares? It's too much.

A universal truth is that prevention is more effective than treatment; that is to say, it is easier to deal with those who do not smoke than it is to stop them after they have started. I'd introduce at this point that the prohibition of sales through unattended vending machines is a must.

I've heard the argument that pharmacists are better able to counsel patients for smoking cessation if they're selling the product. No, I don't think so. Sorry, but this just doesn't wash. I do not believe that selling tobacco products will enhance our ability in counselling a smoker on how to quit. This is ridiculous in fact. To think, on the one hand, we'd place a four-by-six sign saying, "We have the lowest price on tobacco, come in and buy some," and in the next breath counsel a purchaser to stop smoking—no, hardly.

Then there's the level-playing-field theory where pharmacies, as retailers, should be allowed to sell any legal product if any other retailer can sell it. Does this mean that a tobacco store should be able to fill prescriptions, or are they already? No, of course not. Some retailers can sell one thing and others are allowed exclusive rights to sell others, and thus it has been for a long time.

The hue and cry from tobacco sellers who wish to continue selling tobacco products is that pharmacies may be forced to close. My answer is, yes, some pharmacies will close. It is, however, unlikely that the prohibiting of tobacco sales is the only cause for their closing.

A study by the CPhA in 1992 showed that of 56 pharmacies that voluntarily eliminated tobacco sales, 59% either had no income loss or an increase in overall sales; 13 had marginal losses and 7 had moderate losses. However, all 20 of the latter had recouped in the next two years.

The handwriting for sales of tobacco products in pharmacies has long been on the wall; you just had to read it. If one has not tried to make plans to overcome the lost revenues from tobacco sales, then I'm very much afraid they have made a business error. Plainly and simply, they have shaken the dice and they have come up snake eyes.

We discontinued tobacco sales in our two North Bay stores in April 1991. Although our sales for the two stores in tobacco in 1990 were about \$800,000, we did discontinue the sales. Through positive efforts, these losses have been regained and surpassed, without reducing staff, I might add.

One of the most bizarre arguments for retaining the right to sell tobacco in pharmacies is the scenario where if pharmacies don't sell tobacco, then kids will buy from smugglers. I find it hard to take this seriously, and in any event, this would be dealt with as a matter for the police. Although pharmacists may be concerned as citizens, that should be about it.

The message must be clear: Tobacco products kill and pharmacies sell health items, so pharmacies should not sell tobacco products, period.

Speaking from personal experience, I must say that we were quite surprised at the public's reaction to our discontinuation of tobacco sales. Many people sent us letters of support and commendations. One went so far as to send North Bay Guardian a plaque which we display with pride in the back of the store. In other words, our experience was consistent with CPhA study results. The medical community was also very supportive.

Initially, there was a considerable dollar loss in revenues per month, but sales volume did come back and our sales surpassed those we had in the tobacco-selling days. No one wants to take losses, but there is a time to take a stand on what is right. This is that time. Both government and pharmacy must seek either economies or new sources to replace revenues given up by the reduction in sales of this product.

Pharmacy is an old profession which has long been an honourable and trusted one. Let us not confuse the issue. It's a health-providing profession. Let us be that.

1100

**Mr Jim Wilson:** Thank you for your presentation. We've been told by other independent pharmacists that actually it's a bit of a myth that pharmacists have a real monopoly, and it's been pointed out to the committee that anyone can set up a pharmacy, that you simply have to meet the requirements and get college certification, and that's quite true. Pharmacies are popping up everywhere: in the back of A&P stores, in Eaton's and Loblaws. We were told all you need is running water and you have to meet the physical criteria of setting up a dispensary in your store and a few other fairly simple—and hire a



pharmacist, of course. Any retailer can get into the business. You posed the question, could a tobacco shop under today's laws set up a pharmacy? Of course they could.

I want your comment on that because it's been suggested to us that perhaps we wouldn't be receiving such negative reaction from those pharmacists who don't want to see a ban on tobacco products if there was more of a monopoly on selling prescription drugs, if there weren't so many pharmacists in the business. A lot of people tell us that because there are so many pharmacists in town they really had to expand their retail trade at the front of the store and part of that is that they sell tobacco products, often as loss leaders, to bring customers into the store so they can make money and be in business.

What are your thoughts with respect to perhaps we should be looking at the regulations of the college and its criteria for setting up pharmacies and tightening those?

**Mr Robertson:** I'm not sure altogether how to address that. It's been, up till now, very difficult for a tobacco shop to set up.

*Interjection.*

**Mr Robertson:** It could be a hardware store. I don't care. It doesn't matter. You can buy a pre-1953 charter from somebody, I suppose, and set up a pharmacy.

**Mr Jim Wilson:** No, you don't even need that.

**Mr Robertson:** You don't? You don't need that?

**Mr Jim Wilson:** No. Anybody can set up a pharmacy, yes. That's their point.

**Mr Robertson:** I wasn't aware of that, actually. It's never come up.

**Mr Jim Wilson:** They think it's too easy. The law is very clear. There's a certain set of criteria you have to meet and as long as you meet that—this is the evidence they're giving us—there aren't too many people turned down.

**Mr Robertson:** I'm not aware that that's the case. If it is, then possibly they should be looking at something like that.

**Mr Larry O'Connor (Durham-York):** Thank you for your presentation and for coming here this morning. As you know, this legislation is just a part of the strategy, and the strategy's been laid out pretty clearly since the Premier's Council report, the strategy laid out in 1992, a discussion paper in January 1993 and then hearing from people.

The draft legislation was circulated and over 240 people made written presentations and 34 oral presentations to the Ministry of Health officials in drafting this legislation. In doing so, we heard from people saying that the licensing could impact negatively on small business, add an additional drain on it. Then we've heard from people saying that we should go to a licensing system because that little licence up in the corner is something that the retailer would be proud of. Of course, the licensing then goes to some pretty strict enforcement. I think the enforcement is in the legislation—

**The Vice-Chair:** Question.

**Mr O'Connor:** Thank you—and the key here I think

is getting the message out to the people we're targeting, the young people. It is not the licence up in the corner but the sign before the people when they go in to purchase it, then of course the statutory prohibition if they're caught selling to minors and then some signage saying this store has committed the offence of selling to minors.

How would you, as a pharmacy owner, feel if a pharmacy wasn't included in this but was then subject to—and we've been hearing nothing but wonderful things about how pharmacists would never sell to a minor—all of a sudden pharmacists are being charged under the legislation and have signs put up there saying that this pharmacy and then of course your colleagues have been selling to minors? How would you feel if that was the situation, because clearly it would happen?

**Mr Robertson:** Obviously I don't think they should be selling in a pharmacy, so that wouldn't be a case as far as that goes.

**Mr O'Connor:** I agree with you. Thank you.

**Mr McGuinty:** Thank you very much, sir, for your presentation. First of all I want to commend you for taking tobacco products out of your drugstore and I think we should all be endorsing patronizing drugstores, pharmacies, which don't sell tobacco products.

Obviously this issue is the subject of some controversy. We're going back and forth here with pharmacists bringing opposing positions to the committee. I personally don't feel that the removal of tobacco products is a step which is going to have any measurable effect in the war against tobacco. I think there are some 1,400 pharmacies in the province which sell tobacco products and there are 120,000 cigarette retailers, and I just don't see the symbolic value when you juxtapose that with a greater symbolism, which is: "Well, Mummy can still smoke. Daddy can still smoke. Uncle So-and-so can still smoke. When you're 19 you can smoke." I just don't see how that's going to make any significant dent in that.

What I really appreciated though was the way you prefaced your comments as seeing the law as kind of a last resort. In that context I want to ask this question. This bill also addresses vending machines, again the primary purpose being to make it tougher for kids to get hooked. Do you think it's fair that we ban vending machines from bars?

**Mr Robertson:** I don't see what difference—if it's in a bar then you're not going to get children. I suppose you can make a case, much like a health facility. I saw somebody mentioning something about some advocate for mental patients—

**Mr McGuinty:** Right.

**Mr Robertson:** —and they seemed to make sense. I guess nothing is carved in stone.

**Mr McGuinty:** Right. I might add, just on a point of personal interest to you, my relations in North Bay are very disappointed that you banned tobacco. They run McGuinty Funeral Homes.

**Mr Robertson:** Ah, yes.

**The Vice-Chair:** Thank you for your presentation, Mr Robertson.



**SUDBURY GENERAL HOSPITAL AUXILIARY**

**The Vice-Chair:** The next presentation will be by a representative of the Sudbury General Hospital Auxiliary. Would you please come forward, introduce yourself and proceed with the presentation. Welcome.

**Mrs Lois Nault:** My name is Lois Nault, president of the auxiliary of Sudbury General Hospital and chairman of region 10 of the Hospital Auxiliary Association of Ontario, also known as HAAO.

Our auxiliary was founded in 1949, before our hospital was officially opened in 1950. As a supplementary source of revenue, besides our bake sales, teas, raffles etc, we started a tuck shop in a corner of our front lobby. We sold chocolate bars, chips, gum and tobacco products. A few years later we were given a permanent location on the front main floor near the switchboard. We increased our sundries with pop, infants' wear, magazines and more tobacco products. Our revenue kept rising as a result, so we expanded the size of the shop to accommodate our growing volume.

Twenty years ago our board of directors suggested we consider eliminating tobacco products from our shop for health reasons. We discussed the matter with our members and, although we knew it would definitely cause a drop in our revenue, we all agreed, as a health care facility, we should not be selling tobacco products that are a threat to one's health.

The first few years after eliminating them, our revenue did decline, but we have always been very innovative and determined ladies. What we did was to diversify by expanding our shop again to make it big enough to sell coffee, tea, hot chocolate, more hand-knit items, fresh and artificial flowers and a larger gift line etc. Our revenue increased significantly from then on, and so much so that a few walls were torn down to make it even bigger.

Currently, we provide sandwiches, several kinds of pastries, a hot chocolate machine was installed, fresh cookies and butter tarts, parking tokens, stamps, bus tickets and Nevada lottery tickets. Our motto is, "If we don't carry it, we will do our utmost to accommodate your request." Hospital staff, doctors, volunteers, visitors and patients are our very best customers.

In conclusion, we still firmly believe that we made the right decision 20 years ago to eliminate all tobacco products from our shops. As we all know very well, heart disease, strokes and heart attacks, lung cancer, bone cancer and other health-related problems are definitely linked to the use of, and abuse of, any tobacco products.

As an added note to this, our revenue has gone up every year since and our donation to our hospital in 1993 was \$182,000, and we are sure we will surpass that amount again this year. Thank you.

**The Vice-Chair:** Thank you for your success story.

**Mrs Nault:** That's short and sweet.

**Mr Jim Wilson:** Thank you, ma'am, for being right to the point. I guess the way I look at this is, and I certainly agree with your decision not to sell tobacco products in the tuck shop of a hospital or in that case any major health care facility. That's where, with respect to the pharmacy thing, we differ with the government in

terms of when I go into a Zellers store that has a pharmacy at the back, I don't think of the Zellers store as a health care facility. Yet, under this law, it will be considered a health care facility because it has one department out of, we've been told, over 30 departments that happen to be a drugstore.

**1110**

I have no problem and I don't think the public has any problem realizing a hospital is a health care facility. In fact, I would think it abhorrent to be selling tobacco products in a hospital tuck shop and I've always thought that. I used to always think, because I did volunteer work in a hospital when I was in university, it was pretty bad that people were huddled in smoking areas in hospitals, although I have some sympathy—it's been pointed out that we have to look at the veterans' case, in the case of Sunnybrook hospital in Toronto, where they have a veterans' wing, that perhaps we'll have to make an exception there.

But do you have any thoughts on the non-traditional pharmacies that are going to be hit by this ban and do you think consumers can't tell the difference between a retail store and the pharmacy at the back of the store?

**Mrs Nault:** The stores that sell sundries and food and have the pharmacy at the back, I think that they're separate, actually, in some ways because it is in a different area of the store or whatever. But I'm in agreement that they shouldn't be selling them; I don't think it's wise. But where else are they going to sell them? People are going to be buying them. Definitely their revenue will go down, they have a point there, but as we were saying, it is a store or a shop where they sell drugs for health reasons, so one is counteracting the other. If you're going to be selling tobacco and you're selling other things besides, they don't seem to go together.

**Mrs O'Neill:** Thank you so much, Ms Nault. Is there a provincial association of the auxiliaries of the hospitals?

**Mrs Nault:** Yes.

**Mrs O'Neill:** I really think you should send this brief to them. I had a little more experience than I wanted in hospitals in 1993, with very close relatives being involved, and I'm not sure that every hospital is where you're at with their tuck shops. I do know that for one of my relatives, trying to give up smoking in the hospital, a fresh cookie would have been very helpful to have when he wanted a cigarette.

I really think that you have in your brief—and I was just saying to my colleague that we can say quite a bit in 432 words—said a lot. I think you've shown and I hope those who are here this morning and those who will read the Hansard will find that you have shown there are other ways to serve customers, there are options to be offered and I think you've done a very good service to this committee, so thank you so much for coming.

**Mrs Nault:** Thank you.

**Mr Perruzza:** More a comment and a reflection than really a question: I come from a country where when someone becomes a doctor or a pharmacist they occupy a very privileged and responsible place in society. They have pharmacies there and I don't think anybody would

get into that area if their aim was to sell or promote cigarettes or promote anything other than their craft, which is dispensing medication and providing a health care service. So it's quite interesting. That's not necessarily to say that they have a lower ratio of people to smoking but I think it has to do with what that office essentially carries with it, and with it, it carries a high degree of responsibility, and to promote cigarette sales or to sell cigarettes by a highly respected, responsible person is, I think, irresponsible. I just make that observation.

**The Vice-Chair:** Did you wish to comment?

**Mrs Nault:** Yes, I'd like to make a comment. As I mentioned in my introduction, I am chairman of region 10 of the Hospital Auxiliary Association of Ontario. My area extends to Wawa, down as far as Parry Sound, down as far as Mattawa and all points in between. None of the tuck shops in my region sell tobacco products and have not sold them for quite some time.

**Mrs O'Neill:** Wow. That's quite a record.

**The Vice-Chair:** Thank you very much for that information and your presentation.

WILLIAM WILSON

**Mr William Wilson:** I'd like to thank you for coming to Sudbury and giving us the opportunity to speak to you. My name is Bill Wilson. I'm a pharmacist from Sudbury. I'd like to speak to you from three perspectives, first as an ex-smoker. I'm a reformed sinner and I suppose we all tend to be quite strident in our views about our former vices. I'm no exception. I quit smoking about 20 years ago and my views, rather than mellowing with time, have become more rigid. I just have no tolerance for the use or sale of tobacco products.

Second, I speak to you as the council member for the Ontario College of Pharmacists for district 14, which includes a great area of northeastern Ontario. I support the position of the college of pharmacists in this matter and I would like to thank the current government for bringing forth the legislation that will enable the implementation of the college's recommendations regarding the sale of tobacco products in pharmacies.

Third, and I think most important, I speak to you as a pharmacist and pharmacy owner. My partner, who is also my wife, and I own two pharmacies. One is South End Apothecary, and "apothecary" is just a funny way of saying pharmacy for those of you who don't know that. It's located in a medical building here in Sudbury. We opened it about three years ago and we've never sold tobacco products at this location. The second pharmacy, Wilson Pharmacy, is located in Copper Cliff, which is just underneath the smoke stack over there to the west. Copper Cliff is now part of the city of Sudbury. The pharmacy has been in my family since 1911, when my grandfather came to Copper Cliff and purchased it. My father owned it and now I own it. It's more of a traditional pharmacy, selling a mix of products. We did sell tobacco products there at one time.

I stopped selling the tobacco products in the mid-1980s. I can't give you an exact date because at the time I didn't think it was such an important step; it was something that I felt very strongly about. I was prepared

to take that step regardless of public opinion. This move was made before it became fashionable to stop selling tobacco products in pharmacies and it was met with some objection and ridicule by the public. Nevertheless, we proceeded and most people were supportive of the move and respected my forgoing financial gain in favour of upholding an ethical principle. As it turned out, we did not suffer financially because of that decision and we did gain a measure of respect in the community.

I don't think I have to revisit all the financial issues involved here, as a previous presenter mentioned the Canadian Pharmaceutical Association survey which showed that most pharmacies did not suffer major financial consequences when they stopped selling tobacco products. Heart Health Sudbury did a survey locally here this past summer and it found that 19 of 38 local pharmacies no longer sell tobacco products. As far as I know, no pharmacies have gone out of business due to stopping the sale of tobacco products.

I've heard some pharmacists argue that tobacco products should be sold in pharmacies because as health care professionals we're better qualified to monitor their use and counsel customers regarding the possible side effects. I submit that if their tobacco products are located in the dispensary, then perhaps they can monitor their use. Otherwise, I just can't follow this line of reasoning, and I can't see that anyone, any pharmacist, is going to have cigarettes in their dispensary and sell them through their dispensary.

1120

The decision of council: It's really that we're sending out a message here. It's a symbolic gesture that we as health care professionals do not support or condone the use of tobacco products. We're telling the public that smoking is harmful. This is a very laudable message and I support it. I'm trying to sell it within the profession. I think a lot of pharmacists have bought into that message. It's becoming increasingly difficult to get that message across, though, when various levels of government are cutting taxes and caving in to groups that threaten to break the law or that are breaking the law. We're getting mixed messages here, and I think it's important that all levels of government send out the consistent message that smoking is unacceptable. In any event, I'm sure you've heard a lot about that, as well.

I guess I just have to express, on a personal note, a very strong sense of frustration as a pharmacist that we are trying to send out this message and we are giving up financial gain and the government cuts taxes, which will increase the use of tobacco. It's a very frustrating feeling and I'm trying to search for the appropriate words to express that. I suppose "outrage" is one that is overused now. I guess "disgust" would be a better term to sum up my feeling about the whole thing.

Anyway, there will always be someone who will cry wolf when any action is taken that may financially affect some segment of society, but in business there are always financial adjustments to be made, whether it's a result of changing markets, new competition or the result of changes in government regulations. We as a society cannot condone something that is wrong purely for



financial considerations. After all, is it right to continue shelling the women and children in the markets of Sarajevo because the soldier on the hill might lose his job or some arms manufacturer may have to close down his factory? Is it right for a profession that is charged with protecting the public health to continue selling a product that kills thousands of people each year? The answer is clearly evident.

In closing, I would just like to share with you something that happened in one of my stores recently. I have an elderly couple who are clients of one of my pharmacies. The wife has chronic obstructive pulmonary disease. We dispense inhalers and other medication that enable her to breathe, and she continues to smoke. Her husband, a non-smoker, or perhaps an ex-smoker, has recently developed cancer of the larynx. If I was sending cigarettes along with her prescriptions used to treat the cancer and the lung disease, I could not look in the mirror in the morning. Thank you.

**Mr Jim Wilson:** Thank you for your presentation. I think you make a couple of very good points.

**Mr William Wilson:** Could I just correct one thing that you said earlier? Not anyone can set up a pharmacy. The shares of a pharmacy have to be 51% owned by a pharmacist, unless someone goes and buys a pre-1954 charter which contains a grandfather clause and allows them to set up a pharmacy. But otherwise, you do have to have 51% ownership by a pharmacist. Sorry for interrupting.

**Mr Jim Wilson:** No, I understand that. In fact, it's a good point. Could the research people please provide all members of the committee with the criteria required to set up a pharmacy? I was reiterating evidence that had been given by pharmacists, telling us that they felt part of the problem and pressure on them was that anyone can set up a pharmacy. I'd be happy to send you the Hansard in that regard.

**Mr William Wilson:** Okay.

**Mr Jim Wilson:** Secondly, I thought you made a couple of good points, though. Government, particularly all governments, this government and previous governments in Ontario, are addicted to the \$800-million worth of revenue we get from cigarette sales. It used to be \$1.2 billion, and it's actually declined now because of the underground economy. I think that no matter what government does, it will always be sending out mixed messages. Mr Laughren's first response, some two weeks ago, to the possibility that the feds would eventually lower the taxes was, "I can't give up the revenue." It was not a health response, interestingly enough.

The question, though, I want to ask you is with respect—I don't think we'd be in this position if more pressure had been on pharmacists with respect to the voluntary ban that was in place. I've asked groups why we didn't see the big press conferences and all of the groups really hitting pharmacists hard so that government wouldn't be put in the position of having to impose this ban. Now, you mentioned you've made personal efforts to try and convince colleagues. Did you feel enough was done? Because frankly, I was Health critic and I didn't even know for quite a while that there was a voluntary

ban in place. That's how well publicized it was.

**Mr William Wilson:** It may not have been publicized outside the profession, but it certainly has been publicized within the profession. The college is the one that passed the resolution and asked the government to bring forth the legislation enabling the ban of the sale of tobacco products in pharmacies. It was a resolution made by the Ontario College of Pharmacists, and this resolution was reinforced last June; the college did vote again last June and reaffirmed its decision at that time. So it is an internal—

**Mr Jim Wilson:** Well, it's external now.

**Mr William Wilson:** That's because the Ontario College of Pharmacists cannot pass the legislation, as is my understanding. They pass a resolution and then, as a self-governing body, they have to send that recommendation to the government, which brings forth the legislation and passes it, which then becomes the law of the land.

**Mr O'Connor:** In fact, that's why they came to the committee.

**The Vice-Chair:** Thank you. Mr Wiseman.

**Mr Wiseman:** Thank you. I understand—

**Mr Jim Wilson:** I'm not finished; I just want to make a point on that. That's my point. I know the college can't do it and that this is the process. They weren't given the power to do that under the Regulated Health Professions Act. My point is, if it's such a good idea, why couldn't the college convince its own members and why throw it in the government's lap?

**Mr William Wilson:** I guess the college felt that it was an issue that shouldn't be left as a voluntary decision. After all, there are other areas of practice that are mandated, that are part of the legislation. If they were left up to the discretion of each individual pharmacist, then there would be quite a discrepancy in the levels of practice by various pharmacists. Some things have to be enshrined in law. I guess the college at the time—I was not a member of the college at that time—felt that this was such an issue and that it was important to have a standard level of practice throughout the profession in regard to this issue.

**Mr Wiseman:** I would like to quote from Floyd Laughren and what he said about lowering the price of tobacco. He said, "The smuggling of tobacco products is a very complex issue, and this quick-fix solution can only have serious long-term health effects." He also said: "There are no winners in this situation. Non-smokers will obviously be affected by the revenue loss and smokers will lose as well, since cheaper cigarettes will almost certainly lead to an increase in smoking and all the health problems that go with it." I think the Finance minister is clearly communicating that there is a huge concern about the increase of costs due to cigarette smoking. It's interesting that—

**The Vice-Chair:** Do you have a question, Mr Wiseman?

**Mr Wiseman:** Yes, I'm getting to that question right now.

1130

It's interesting that the Ontario Hospital Association has indicated that there has been an increase of over two million visits to hospitals from last year to this year, so you have this huge increase in terms of costs.

My question is that when you were talking about example, I believe that really the only way we're going to slow down this cigarette smoking is by example, and I agree with you that if all of the pharmacies and all of the health people were sending the same message to young people, they would see it as well, that smoking is not something they should start or get involved with.

**Mr William Wilson:** I agree with you. We've been sending out this message for a long time and this is just one more reinforcement of that message. I think the biggest stick has been the financial one so far, and that has been the biggest deterrent to smoking. But it's important that we keep hitting home with this, whether it's setting aside smoke-free floors in hotels or smoke-free areas in restaurants or pharmacists standing up and saying: "This is wrong. We cannot sell tobacco products because it's detrimental to your health." All these things are important. No one message is going to stop people from smoking, but it's a cumulative message and it's important that we're consistent and keep going in the right direction. We don't want to have backward steps, and reducing the taxes is a step backwards. If the Minister of Finance provincially is reluctant to lower taxes or is against it, I applaud him for that. Unfortunately, I think there's been a lot of harm done already by moves by other levels of government, but that's not the concern here.

**Mr McGuinty:** Mr Wilson, thanks for your presentation. One of the statements you made in your presentation here is: "Is it right for a profession that is charged with protecting the public health to continue selling a product that kills thousands of people each year? The answer is clearly evident." Who could disagree?

**Mr William Wilson:** That's right. I can't.

**Mr McGuinty:** But I have to ask you, is it right for us as political representatives to allow an industry to continue to reap profits in the province at the expense of the health of our citizens? I think the answer there again is the answer is evident. No, I don't think it's right either.

**Mr Perruzza:** I don't understand the question.

**Interjection:** It's not addressed to you.

**The Vice-Chair:** Proceed, please.

**Mr McGuinty:** The distinction we have to draw is between what's right and what's legal. If we wanted to do what was right, we'd ban tobacco today in the province. That's the difficulty that I think you can see that we all face. I just don't see how doing what is right in connection with pharmacists will have a significant effect in the big picture.

**Mr William Wilson:** I'm not saying it will have a significant effect in the big picture. I'm saying it's one more message. It's one more little message that's getting out. By banning the sale of tobacco products in pharmacies, it's not going to stop people from smoking, but it will send out that message. If you can't see that, then I don't think there's anything I'm going to say that's

going to convince you, but it's an important message. It's important as a profession that we are consistent in this message and I think it's important that people realize that there are professions that are interested in the public health that are willing to stand up and say, "We will forgo this income in the better interest of society, in the better interest of public health."

Will the government do anything? Will the government stoop to anything to make money? There are times—

**The Vice-Chair:** Would you like to answer that question?

**Mr Jim Wilson:** Casinos.

**Mr William Wilson:** Well, I don't think I had better. No, really, I don't mean to be here to run down anything else. I'm trying to speak in support of this measure. I realize that politicians have a great many things to consider when they're making decisions and you can't just say that tobacco's going to be illegal today and have society accept that. It has to be a continual educational process, much the same as educating people about diet in regard to heart disease, just public health and all aspects of it. It's an educational process. But the symbols are important and this is a symbol, and I think that is the message that has to get out.

Personally, I can't sell tobacco products. I'm just violently opposed to it. But I think it's important that that message get out to the public, and perhaps someone will listen and realize that tobacco products are harmful, because in spite of all the messages that are getting out today, there are people who still don't realize it. If we took someone in and showed them a smoker's lung and it was full of tar and you had to scrape the gunk off it, that might get the message across. But we can't do that, so we're using this symbol.

**Mr Perruzza:** Mr Chairman, I'd just simply like to take off my hat to this gentleman and hope that Mr Bill Wilson continues to do well.

**The Vice-Chair:** I'm sure we all join you in that comment. Thank you very much. We appreciate your presentation.

LYLA BURNETT

**Ms Lyla Burnett:** Ladies and gentlemen, thank you for allowing me time to speak today. My name is Lyla Burnett and I am from North Bay, where I've been employed for the last 13 years as a pharmacy manager at Pharma Plus Drugmart, a retail pharmacy.

As a pharmacist and retailer, I am concerned with Bill 119 and its impact on my store and the community. Presently, tobacco sales are approximately 14% of total store sales. This figure converts to a customer count of about 1,000 people per week. By eliminating tobacco sales in this pharmacy, there would be a decrease in both sales and customers to the store. The net result would be at least a 10% profit loss, which would result in at least a 10% reduction in employee hours. This translates to about 40 hours, or at least one full-time job in our store.

This figure could in fact be higher, because a decrease in customer traffic will affect other sales as well. Sales of confectionery and sundry items will drop with less store traffic. As well as the effect on the store sales and



staffing, and perhaps more importantly, it's unrealistic to think fewer people will smoke because they cannot buy their cigarettes at a retail pharmacy.

Bill 119 may actually increase contraband cigarette sales because fewer retail outlets would be selling cigarettes legally. As for minors purchasing tobacco, our pharmacy, at least, has been diligent in enforcing laws concerning tobacco sales to minors. If laws governing tobacco sales are to become tighter, are pharmacies the ones to pick on? Why should one type of retailer be singled out as a culprit? If tobacco sales are to be effectively limited, then perhaps a designated licensed dealer for these products, similar to alcohol sales, would be a better choice. If this were the case, pharmacies already handle items with restricted access, such as schedule C products.

In conclusion, the intention of Bill 119 may be honourable, but I feel its results will be negative in its effect on pharmacy retail business, negative in its effect on employees of this business and, most importantly, will not have the positive effect on tobacco sales, or specifically sales to minors, that was intended. Retail pharmacy businesses should be allowed to decide for themselves whether to sell this legal product.

**Mrs Cunningham:** Thank you for appearing today. There are many parts of this legislation where we're not clear what the regulations will be. We're hoping to get that during the clause-by-clause or before that, I would hope, from the government.

There are other parts that some of us would like to see strengthened, where we would make amendments. For example, we talk about the school building. Many of us would expand that to say the school property if you are going to say young people shouldn't smoke. We would make it more clear in the legislation. That's just an example.

1140

You interested me because I feel very strongly that retailers should be licensed. That would be an amendment that I would hope we would put forth for the consideration of the government. We're heard it from many groups. Some have gone so far as to say that these cigarettes, if sold at all, should be sold in the liquor stores so that you're really prohibiting young people under age.

I'm wondering how you feel about making the young people who are under age responsible, because personally—if they're breaking the law, I wonder what you think the penalty should be, if at all.

**Ms Burnett:** If they're caught smoking? I'm not sure I understand your question exactly.

**Mrs Cunningham:** Smoking or purchasing cigarettes in public is not unlike drinking alcohol, and that's illegal. So, really, this is so far a legal product, isn't it?

**Ms Burnett:** Yes.

**Mrs Cunningham:** How far would you go? That's my point.

**Ms Burnett:** I certainly don't disagree that the age should be raised for selling tobacco. I'm not a smoker and I'm not here to advocate that smoking is good for

your health. It's not. Certainly I agree that we have to try to both educate minors and somehow enforce more strongly, get that message across to minors.

As far as what we could do to enforce it, maybe, if caught, some kind of volunteer service with a cancer society or lung association or something like that to make them more aware of the hazards of smoking.

The point I was trying to make is I really don't think that by eliminating tobacco sales from pharmacy, you're going to stop any young person from smoking.

**Mrs Cunningham:** I personally agree with that. Given the intent of the bill, it's my personal opinion. "The bill is intended to prevent the provision of tobacco to young persons and to regulate its sale and use by others." It's that simple. It's one line. So if we in fact are introducing pieces of legislation that will not prevent the provision of tobacco to young persons, I don't agree with it, so I obviously share your view in spite of all of the ideology. I certainly question some people who are in the health professions who want to sell it, but I don't think making laws is going to fulfil the purpose of the bill. Therefore I agree with you.

But if you would give it some thought, I think your idea of community service is most commendable. That's the kind of thing we want to make recommendations on to the ministry with regard to how we feel the regulations should fall in place.

**Mr Wiseman:** I'd like to ask Ms Mitchell if she could perhaps clarify the difference between the statutory prohibition in the bill and the whole concept of licensing, and why the bill has statutory prohibition instead of licensing.

**Interjection:** That's a trick question.

**Mr Wiseman:** That's actually from the parliamentary assistant, and he's transferred it to you so you can answer.

**Ms Brenda Mitchell:** We looked at the options of licensing systems which we'd had recommended to us by groups and the option of an automatic prohibition. I'll try to explain how the two different systems work, and that may clarify why we made the choice that the government did. I'd also like to help clarify that a licensing system for all tobacco retailers is different from the option of selling through liquor control stores.

If a licensing system were to be established, it would require that all tobacco retailers obtain a licence. In order for that licence to be issued, a bureaucracy would have to be set up to review the applications. If someone demonstrated knowledge of the law and there was no reason for past conduct to not give them a licence, they would be issued a licence.

Once a tobacco retailer had a licence, if it was thought that they had contravened the law, they would then have to be notified of the contravention and given a time period in which to come into compliance with the law.

If they didn't come into compliance with the law or had a second contravention, then there would be an administrative tribunal in place. So, once again, another organization would have to be formed to review whether or not there should be a suspension or revocation of the

licence. Once the tribunal had made its decision, if the retailer chose to take issue with it, they could appeal it to the court before a final decision would be made.

What we have heard from many groups is that they are looking for a fairly efficient way to have a strict penalty put in place for contravention of the act, and what we are proposing is an automatic statutory prohibition so that, once there was a second conviction, an automatic prohibition would come in place for a defined period of time prohibiting the sale of tobacco from that premise during the period.

**Mr O'Connor:** The statutory prohibition is located right underneath that table in your act.

**Mr Perruzza:** I just have a five-minute question.

**The Vice-Chair:** Just a moment, please. I must go on to the next speaker. I'll come back to you.

**Mr McGuinty:** Ms Burnett, watching the various pharmacists come before us here is somewhat akin to watching a ping-pong match in terms of the difference of positions that you bring. It's obviously a source of a great deal of controversy. We heard from a Mr Wilson earlier, who was a member of the council, who's very much in favour of the legislation. Yesterday at Queen's Park we heard from another member of the council who expressed the opposing opinion. Why is it that you're not going along with what your college decided?

**Ms Burnett:** Pharmacy is both a profession and in many cases it's a retail business as well. Unfortunately, in a retail store we're faced with the dilemma on one side where we're operating the actual professional pharmacy but we're trying to operate a front shop as well. Now, there have been government cutbacks in fees and what not and we've been told, "Well, you have to make that up in your front shop business." If you run a small professional pharmacy, that may be possible. If you run a large retail pharmacy, it becomes less possible if you're being told that you can't sell some kind of legal product. I think that's where the dissension comes within the profession itself. We're all professionals, but some of us are retailers as well.

**Mr Perruzza:** You may want to answer this; you may not. If everyone were to get well tomorrow and required no more medication, what would you do?

**Ms Burnett:** It would be wonderful.

**Mr Perruzza:** What would you do?

**Ms Burnett:** I don't know what I would do.

**Mrs Cunningham:** We wouldn't need a government.

**Mr Wiseman:** That sounds good to me too.

**Mr O'Connor:** At least we have a government focusing on wellness.

**The Vice-Chair:** Thank you for your presentation and answering questions. We appreciate it.

BRIAN BAGGS

**Mr Brian Baggs:** My name is Brian Baggs. I'm a volunteer with the Heart and Stroke Foundation of Ontario and I'm honoured to represent the Heart and Stroke Foundation here at these hearings.

You have the brief before you and I'm not going to go through in intimate detail or line for line. I'm a volunteer,

as I said, with the Heart and Stroke Foundation, Sudbury branch, and I'm very honoured to represent the views of the Heart and Stroke Foundation but as well my own views.

Although our brief covers many aspects of the Tobacco Control Act, I would like to concentrate on our youth. That's the emphasis I'd like to place today, if I could, the concerns, problems, education and prevention, especially in the area of packaging and retail licensing, which I think have a great effect on our youth.

#### 1150

I'm a father of three, two still teenagers. I'm a former smoker who had a heart attack and open-heart surgery, so I speak from a little bit of personal experience along those lines as well. I'm also a high school teacher, and I know full well the great impact cigarettes and smoking have on our youth, I know the impact peer pressure has on our youth and I also know a great deal of the influence role models have on our youth, either as a teacher or as a parent or in the media or as the sports heroes and rock heroes indicate in their actions to our youth. So I know there are many life decisions that young people have to make, either in a positive or a negative nature.

But to me personally and to the young people I'm associated with, it's imperative that such a life-threatening social addiction as smoking be addressed very seriously and taken seriously and that strong measures be enforced to help and protect our youth of today for their future.

Every day, I discuss for a few moments, whether it's with the hockey team that I coach, my own children or the students who come in contact with me, the seriousness and consequences of smoking. But I feel, and I sincerely believe this, that it's not near enough. A lot more has to be done to protect our youth from the diseases of cigarette smoking that can occur.

I'd like to address the position on packaging. I think it's vital that we interpret your intent that enforcing plain packaging regulations be enforced with a positive imagery. Also, I would like to stress that young people are influenced by what they see. They're influenced by who models them, and if an adult or an educator or one of your or their peers pulls out a package of cigarettes, they identify it and immediately make social contact with it.

Also, the fact that they can buy kiddie packs allows them to buy cigarettes at a lower price. The events of yesterday indicate that they will also have access—I had a hockey practice last night. Five of my players smoke, despite the fact that we do everything possible to stop them from smoking. We discussed the implications of getting cigarettes at a cheaper rate, and they were very happy about it. Hurray, they can get them at a cheaper rate, despite all the health warnings we advocate.

I'd like to point out that brand image often appeals to the socially insecure and the cigarette is used as a part of a wardrobe. It follows that when these crutches are removed, the appeal and sale of cigarettes could be expected to decline. They look for heroes; they look for identification; they look for belonging; they look for a



social group; and cigarettes offer them those crutches that, if taken away, they may look for other sources and other ways of identifying through things and improving themselves.

On the business of retailing, and I'll be brief here as well, control of sales to minors will not stop all kids from smoking—that's known—especially those who are already addicted. Therefore, although this may not be within the mandate of this committee, I would like you to consider the fact that maybe money and emphasis should be put into education, methods that will help them stop smoking and methods that will help them get better if they have problems with their smoking addiction. I believe the government can do something along that line, either through resources in money, education or whatever materials can be used.

However, some will continue to obtain tobacco from older friends and even from their parents. However, retail stores, in my opinion, are by far the largest supplier of tobacco to minors, accounting for up to 80% of the total youth market in purchasing cigarettes.

Along those lines, I think now that youths can easily purchase cigarettes 24 hours a day, in packages or individually—and these stores unfortunately are very often located where students and teenagers hang out, be it either the school or the arenas—I think any change in availability or proximity will help reduce the sale to minors. It's been proven that children who are turned down on their first purchase attempts are likely to be discouraged from taking up smoking in the first place, if there are prohibitions prohibiting them from doing so.

On a final note that's rather personal, I guess, as an educator, if we came out with a very strong proactive campaign and enforced legislation, I believe it would make it even easier for school boards—this is a personal opinion—and I also believe it would make it easier for schools themselves to eliminate the smoking compounds within our facilities that I personally find very hypocritical. As an educator and health advocate, I find it difficult to educate teenagers about smoking when it's perceived as okay to light up, and legally at the moment not much is done to prevent them from doing so.

I entreat you to read our brief and the other aspects of what we have to say through the Heart and Stroke Foundation.

**Mrs Cunningham:** Thank you, Mr Baggs, for your work with the Heart and Stroke Foundation and for all the other things you do with young people. I think everything you've said today is something that we have been made aware of, but it's nice to see a teacher come forward with your concerns.

I've got a question for you.

**Mr Baggs:** No problem.

**Mrs Cunningham:** On school boards, for the past 20 years in this province, they've always had to deal with the education of young people around the use of tobacco and heart and lung disease, and I think they do a pretty good job. I think most of us would agree that seven-year-olds would point at people and say, "You shouldn't be smoking."

**Mr Baggs:** Correct.

**Mrs Cunningham:** We had someone come before our committee in London who I wasn't proud of, but if we had had the opportunity, we would have told him that teachers do a great job. Where I think teachers haven't been as successful is that when school boards are trying to make non-smoking policies, they haven't always shown the leadership. But you're aware of that.

Given this legislation, we're probably going to ban smoking from school buildings, perhaps expand it to school property, and you know what that means. That means the lady around the corner from the school is going to call your school.

**Mr Baggs:** Exactly.

**Mrs Cunningham:** What do you think the penalty should be for the young people who are smoking on the neighbours' property?

**Mr Baggs:** Off school property, then I think the penalty's inherent within the school system itself. Each school has its own method of handling discipline, but I feel that yes, they are violating—they're off school property illegally. They're AWOL from school. They're skippers, if you want to call them that.

**Mrs Cunningham:** What if they're doing it at 4:30?

**Mr Baggs:** If they're doing it at 4:30, that's it.

**Mrs Cunningham:** You see, we have an opportunity now to do something to help you.

**Mr Baggs:** Right. At 4:30, school is out. They smoke at home, they smoke on the street corners, wherever they may be. It's pretty hard for the school to mandate any kind of legislation once the school hours are over. I think that has to become a provincial-municipal position there. But during the school hours when we are responsible for those students, from 8 o'clock till 4:30, with the support of the government and legislation to give us some teeth, then I think we as educators—and I'm speaking personally here, because I'm not in a position of complete authority in my school; I have superiors.

**Mrs Cunningham:** Whom you influence, I expect.

**Mr Baggs:** I have some influence, yes. I hope to have a great deal of influence.

**Mrs Cunningham:** I hope so too.

**Mr Baggs:** If they would take it seriously enough that this is an infraction, it would be written in the school rules. Just like missing classes, or part of them, just like being absent for a day without excuses, whatever the case may be, whatever discipline problems we do within the school, that could be written right into the school rules, that smoking during the school time, on or off school property, including school trips, including my hockey team—they do not smoke before a game, they do not smoke in the change room, they don't smoke after the game, but once they leave the arena, like every other teenager, they do what they do.

**Mrs Cunningham:** You should know that some of us are seriously thinking of treating this like alcohol and saying it ought to be illegal and there should be some sanctions. One of the pharmacists earlier today suggested that it could be community work. Others have suggested

it should be fines. I wonder what you think about that.

**Mr Baggs:** Yes, I think a first offender, like anybody else, deserves a second chance, and however we deal with first offenders and the seriousness of these crimes—although smoking is a serious thing and I don't want to demean it—they should be approached, "You have violated the rules here now." The next time, yes, a fine would be perfectly acceptable to me.

**Mr Wiseman:** I'd like to try this from a different tack. I think if the committee does decide to go with banning smoking on school property, it's going to have to pick a couple of hundred yards on public property around there so they just don't go across the road or stand on the public sidewalk and smoke.

1200

**Mr Baggs:** I recognize that, but in my estimation it's very simple. Maybe I'm simplifying it. If you're off school property and you're having a cigarette on the neighbour's lawn now, you are violating the rules of the school; therefore consequences are accordingly.

**Mr Wiseman:** The question I am going to pose to you is that I would say that of the kids you deal with, and it was the same when I was teaching, about 95% of the kids would buy into the rules; they'd buy into the whole game. They would say: "Yes, we understand that. We're not going to do it." There's 5%, though, who have always traditionally been the problem. Is that where you see the need to have this real heavy hand or this real heavy punishment being given out?

I know some of those kids are just going to say: "Drop dead. You can do whatever you want to me. You can give me detentions, you can get me kicked out of school, but I'm not going to buy into this."

**Mr Baggs:** You're right, but it doesn't matter whether it's smoking or whether it's adhering to the rules of the school. Those are students that don't buy into anything. I guess we'd have to work very hard at those—I wouldn't want to write them off—maybe through education, maybe through talking and so on gradually you might. It has happened in my experience and maybe yours that from that 5% one of them has come around.

**Mr Wiseman:** It's a great moment but it's not often.

**Mr Baggs:** That's a great moment, but I don't think we should give up on them. I sincerely think that not allowing them the opportunity is the primary source of preventing things; the second one is if they do avail themselves, by whatever means they do, and it's illegal, then there are consequences for it. Along with the consequences, I believe that reinforcement in education and all the other things that go along with it might change. We're not going to cure everybody.

**Mr Wiseman:** Do you think if Doug Gilmour told your hockey players that they couldn't become great hockey players if they continued to smoke, that would have an effect?

**Mr Baggs:** To some; not necessarily all of them, but to some.

**Mr McGuinty:** I particularly appreciated your comments about this idea of a penalty, given that you're an educator. It just strikes me that there's something

perverse about us talking about the problems associated with smoking and the difficulties healthwise that it will bring and yet if I'm 14 I can sit on the curb and smoke my cigarette while the police drive by.

**Mr Baggs:** Right at the moment.

**Mr McGuinty:** Right at the moment, exactly. I want to talk to you a bit about those kids who are in the fiend's grip, so to speak.

**Mrs Cunningham:** The what?

**Mr Baggs:** Who are addicted? Is that what you mean?

**Mr McGuinty:** Addicted right now, yes. Is there anything at your school, and if there isn't could there be something at your school, where we could do something about it, unhook them?

**Mr Baggs:** The agencies, the cancer society, the lung society, the Heart and Stroke Foundation, have reams of materials, educational devices, videos and so on that are available to the students. More could be done in the schools. Because I have a personal bias, it occurs in my classroom almost on a daily basis. I can't say that happens in every classroom; of course not. But through their health courses and so on students are made available to that. More could be done. More speakers could be brought in. More material can be made available. Certainly the schools can do a lot more than they're doing right now.

But I think you need the two edges of the sword. You need the flat side of the sword, the stroking side, the education side of the sword, the health side of the sword, but I think you have to flip it over and have that edge to it. When you have both going and working in conjunction with each other, I think an awful lot can be done for our youth today in schools, in clubs, with hockey teams and so on. It's a real education process, and it has to come from everywhere. It has to come from the grass roots, which I think I'm part of, but it certainly has to come from you people who are at the top. If we can come together like this, we're going to hit the middle. There are going to be fringes, that's life, but hopefully we can get as many people and youth as we can coming together rather than coming against each other. That's my personal opinion about it all.

**Mr McGuinty:** I was thinking in terms of something to be offered at school. I know there's all kinds of literature, and there are videos. Things are kind of told to kids, young people, but I've never heard of a program saying, for instance, "Listen, those who want to quit"—

**Mr Baggs:** Yes, okay.

**Mr McGuinty:** Okay, here's the program. It starts. It's offered during school hours. "This is the positive reinforcement you will get; this is what you're going to get out of this." It has to be apart from, "Stop smoking and you'll get healthier." I don't think that's enough for kids.

**Mr Baggs:** Right, you're absolutely correct. Those programs are quite available through the health agencies and I agree with you that schools should be doing that. That's quite true. I don't know if the department of education is represented here in any stretch or form, but certainly I would like you to take that back to the



minister and have him put that right in the legislation for schools and have it as a school policy. You're very correct in what you're saying. Help is out there. Get it in the schools. Get it to our youth from grades 1 on to 13 and even into the universities, if it's possible, but certainly our adolescents and young people.

There are very active programs from our agencies going into the schools and doing exactly what you're discussing, but it's on a personal basis or an individual basis as a school or teacher. Legislation of that kind from the Minister of Education would be ideal.

**The Vice-Chair:** Thank you for your presentation.

ONTARIO LUNG ASSOCIATION.

SUDBURY-NIPISSING REGION

**Ms Dorothy Klein:** This is Dr Douglas Marr, a volunteer with the Ontario Lung Association and he's also a child psychiatrist.

My name is Dorothy Klein and I am the executive director of the Lung Association, Sudbury-Nipissing region. I represent over 250 active volunteers in the region and over 10,000 regular contributors who generously support this organization through voluntary contributions. Our volunteers are actively involved in promoting respiratory health and preventing lung disease. Our supporters recognize the importance of eliminating respiratory health hazards and products that contribute to disease. Tobacco is a major concern of the many people who support our organization.

Many of our supporters suffer from asthma, bronchitis or emphysema. Exposure to tobacco smoke can be life-threatening to these people and can cause a sudden restriction of the air passages, resulting in acute pain and anxiety. We are not talking about a dainty cough; we're talking about choking and death. Acute asthma is the most common medical emergency in children and is responsible for increasing hospitalization and death rates in our country. Tobacco smoke caused many of these asthmatic attacks.

Annually, 150,000 to 300,000 cases of bronchitis and pneumonia in infants and young children up to the age of 18 months of age are attributable to environmental tobacco smoke. Environmental tobacco smoke can only be removed from our indoor air by removing the source: smoking. Research shows that the removal of tobacco smoke through air cleaning or ventilation is both technically and economically impractical. Quality of life for persons with asthma, bronchitis or emphysema is severely restricted by the fear of exposure to environmental tobacco smoke. This isn't a mere fantasy. Exposure to secondary smoke could threaten their lives. Dr Marr, who has three children with asthma, can certainly vouch for that. It affects where they live, where they go, the school they attend, where they work and with whom they associate.

The Lung Association offers smoking cessation materials and support to smokers who want to stop smoking. We are convinced that tobacco is an addictive and lethal product. The number of students of all age groups that come to us for information about smoking is increasing daily. Our volunteers work with students to

prepare presentations to their peers and we promote the Quit 4 Life program designed by youth for youth. Some of you are aware of the Quit 4 Life program, which is designed for teens 15 years of age to 19 years of age. Students as young as eight and nine years of age tell us how easy it is to buy cigarettes for 25 cents and 50 cents each, and how easy it is to buy a pack at the corner store, gas bar and our health pharmacies.

**1210**

I am a mother of four teenagers. They're 14, 16, 18 and 20 years of age. I know that my 14- and 16-year-old can purchase cigarettes at any neighbourhood tobacco retailer with no questions asked.

Vending machines have been found in public games rooms in our city. Many of our youth congregate in the public games rooms which are located near their schools. Our youth do not have to depend on contraband cigarettes as their source. They know that cigarettes are blatantly sold everywhere and that present restrictions are not enforced.

I spoke to a grade 9 physical education class of 13 girls. Six of those girls, at 14 years of age, smoked over a pack of cigarettes a day. They get most of their cigarettes from home, where cigarettes are bought as a staple with the apples and the oranges and are on the kitchen table. When they go out of the house to go to school, they grab a pack of cigarettes instead of a lunch. They say this keeps them slim. Any money they get buys extra cigarettes. One 14-year-old girl could not remember when she started to smoke.

At almost every school presentation, we hear students confess that they would like to stop smoking but can't. Many admit to having seriously tried to stop smoking at least three times before they're 17 years of age. One 17-year-old told me that he had a choice of renewing his driver's licence or buying cigarettes. He chose cigarettes. He admits to feeling irritable and out of control when he can't get cigarettes. When he doesn't have enough money, he pays five cents a drag.

These youths are addicted before they can really make informed decisions. They are already into addictive behaviour with the irrational logic supporting their addiction. The depression caused by the realization of the power of this addiction is overwhelming to them. We must protect our youth.

We are pleased that the provincial government is taking steps to control the tobacco epidemic that is sweeping our society. Bill 119 is a critical piece of legislation and demonstrates the commitment of both the government and the opposition parties to long-term health and quality of life for Ontario residents. Bill 119 will affect the ability of young people to gain access to tobacco-industry products. It will protect our youth from exposure to the lures of tobacco products before they can fully understand the rights of an informed decision and the profound and long-term effects smoking will have on their health and their future.

Our youth do not realize how fragile and vital our respiratory system is, and that it is essential to our existence. I have here a real set of lungs—and we made

some comment earlier that we should have a real set of lungs here. Well, this is a real set of lungs. They've been fully inflated. That's the size of an adult man's lungs. I use these lungs to show the students the size and the texture of the lungs. They can see the proximity of the lungs to the heart, where the heart sits. We discuss the seriousness of lung surgery and how lung transplants are performed. The lung is the first organ to deteriorate at the time of death, and transplants must be done within a very restricted time frame. The students are awed by this visual demonstration.

This convinces me that they are totally unaware of the implications of the decision to smoke and to expose themselves to secondary smoke. They are attracted by the glitter of the cigarette package and the promotion advertisement. They are attracted by the promises of friendship and social acceptance offered by the lure of the cigarette. The government must not allow our youth to be victims of the destructive ploy of the tobacco industry to lure these young, innocent people into using tobacco products and facing a future of addictive behaviour, ill health, economic hardship and early death. A government with integrity does not allow a lethal, highly addictive product to be marketed to kids before the age of responsibility in attractive, confidence-building packages. The government, non-smokers and smokers alike, must give our kids a chance.

The supporters of the Lung Association are counting on this bill being passed. They applaud the proposal to license all tobacco retailers and to introduce stiff, consistent and enforceable penalties for violation. They applaud the elimination of tobacco vending machines in public and unsupervised locations. They applaud the plain packaging with provincial health warnings. They appeal to the government to address the environmental tobacco smoke issue, especially in public places and in the workplace. We are convinced that smuggling is a legal problem and that the Tobacco Control Act will help to reduce smuggling in Ontario.

Parents and persons concerned about our kids applaud the proposed licensing, control over access of tobacco products and control over the exploitation of the young, the innocent and the naïve. This is the year of the family. This proposed legislation will support the role of parents as they guide their youth.

In closing, I cannot stress enough that the Tobacco Control Act is an essential piece of legislation. It's imperative that Ontario continue to tackle the tobacco issue aggressively, especially in light of the recent announcement to lower the cost of tobacco products in Canada.

On behalf of the Sudbury and District Council on Tobacco or Health, of which the Lung Association is an active member, I would like to invite all the members of the standing committee to a press conference which will be held here in this room at 12:30 today. Your presence will be appreciated, and I thank you for your consideration.

**The Vice-Chair:** Thank you for your presentation. Did Dr Marr wish to comment at this time?

**Dr Douglas Marr:** Just to endorse everything that

Dorothy has said and to applaud the House, the government, for this proactive initiative which I think is very much in the spirit of the family, the child and the protection of vulnerable youth before they can make the informed choice. In the same way that alcohol, driving fast and many other dangerous things are contained, I think we have to look at the much more insidious but equally pervasive problem of tobacco.

**The Vice-Chair:** Thank you. The parliamentary assistant wishes to make a comment.

**Mr O'Connor:** I don't have a question, just a clarification for you. On page 4 of your brief, you've mentioned that you applaud the government for the licensing. The licensing isn't part of the legislation. All the important parts that it has been pointed out to us they'd like to see on licensing are actually in place, and it's very stringent and very tight, but licensing itself isn't. Actually, there was a briefing. My assistant here had mentioned it just before, but I just wanted to clarify that for you.

**Ms Klein:** Thank you.

**Mr Perruzza:** I know this may sound silly, but I'm going to ask it anyway. How would you feel about a picture of that on a cigarette package?

**Ms Klein:** Well, it's certainly very impressive. I'll tell you, if you touch it, it feels like styrofoam. You really, really realize how very fragile the lung tissue is.

**Mr Wiseman:** How many packs a day is that?

**Ms Klein:** This was a non-smoker, actually.

**Dr Marr:** These are very healthy lungs.

**Ms Klein:** These are healthy lungs. It's just that they don't have the blood supply in them any more. That's why they're not pink.

**Mr Perruzza:** Every lung that I've seen is that colour from heavy smokers. When they're not heavy smokers, they're bright red.

**Ms Klein:** That's right, because of being able to see the blood supply. But the blood has been removed from this. The black stuff is really—

**Mr Jim Wilson:** Dried blood.

**Ms Klein:** Dried blood, yes.

**Mr Perruzza:** It's a real shame that we would take up smoking and really damage that.

**Ms Klein:** Most teens don't realize that in a lung transplant you have to have exactly the same size of lung to go in. If you're not going to do a lung-heart transplant, it has to then go right in there, and you have to get the ribcage to go back around this. So you can't take somebody's lung that might be smaller than yours and transplant it, or larger, because it just will not fit in. It's very difficult. So when the kids say, "Oh, well, I'll get a transplant from somebody else," it's not that easy.

1220

**Mr Jim Wilson:** I want to follow up on the point that was made by the parliamentary assistant.

On page 4 you do a lot of applauding. The parliamentary assistant did clear up that this act doesn't do licensing. There are a couple of other things I just wanted to talk about too. Vending machines are being banned



totally, here it's mentioned, "in public and unsupervised locations." Plain packaging, that's not in the act either. There's regulatory authority to deal with packaging and health warnings, but it's not spelled out. You do mention that you're encouraging the government to deal with environmental tobacco smoke, but there's nothing about the workplace in this act.

Do you think, as we obviously feel in opposition, that life would be going a lot easier on these committees if the government would just come forward with its regulations? For instance, we've had a number of groups, and we don't bother correcting them every time, telling us that the government's going ahead to ban kiddie packs. I don't know where people get this blind faith that the government's going to go ahead and do that. It seems to me if the government wanted to do it, it would be in the act rather than this tippy-toeing around. I think the cancer society makes this point actually quite well from time to time. I've actually read in the media that the government's banning kiddie packs and the government's bringing in plain packaging and a number of other things. I don't know what act they're talking about, but it's not this one. I wanted to ask you whether you'd like to see the regulations too, because I think it's time we saw them.

**Ms Klein:** Yes. From a professional point of view, but also as a parent, it's very difficult when it's broad and it can be misinterpreted. You can take it and get all these loopholes, all these other areas.

As a parent of four teenagers, I see that as very important, because teens are at a time when they're challenging, when they're really looking, and that's when it comes out whether we really mean what we say, what we really mean when we put legislation in. Is it going to stick? They're going to check the parameters to see whether or not there are loopholes, and if there are loopholes, it's a heyday, and that's what's happening.

**Mr Jim Wilson:** I appreciate that, because we need your help and other people's to keep the pressure on the government. We're not done in this process yet. Clause-by-clause will be back in Toronto. It tends to be a fairly closed and quick process. If the bill is passed the way it is, we're going to be into an election and you can't depend on anything being done. So we need your help to pressure the government and say: "Do you mean all this stuff? You've been getting great press but it isn't in this act. Let's put your words where your mouth is."

**Ms Klein:** So you're advocating that we really continue with the pressure?

**Mr Jim Wilson:** Keep the heat up. That's what opposition parties do. We get accused of being partisan if we do it, but I think in this act it's just fair.

*Interjection.*

**The Vice-Chair:** Please, shall we take turns? It's helpful.

**Mr Perruzza:** I don't understand them any more.

**The Vice-Chair:** Please. The parliamentary assistant has requested permission to make a comment regarding this matter.

**Mr O'Connor:** The plain packaging I think is an

important issue. It's something that was talked about in the early discussion paper. In fact, at that time the federal government looked like it was going to move in that direction. In the press release put out by the present federal government, they said that they're going to look into it.

We put in the ability, in case the federal government doesn't move on it, that we can do it here in Ontario, because we think that it's important that we move forward, that this is an important issue. We are going to make sure that we have the ability in case the federal government doesn't do it.

**The Vice-Chair:** Thank you for that clarification.

**Mr Jim Wilson:** There's nothing to stop the government from putting it in and then saying if there's a federal act that overrides, the federal act will supersede. It's normal.

**The Vice-Chair:** Thank you for your comment.

**Ms Klein:** I just wanted to comment on the importance of the plain packaging. Last night I stopped at a corner store here in Sudbury. Behind the counter where you get the cash, the whole wall was cigarette packages with the glitter. There was duMaurier, there was Player's, there was Export, all of it. Anybody coming in, they didn't see the Hostess potato chips. They were in the back. That was what was the most attractive decor for this store, and this was across the road from a high school.

**The Vice-Chair:** Thank you for pointing that out. The final question by Mr McGuinty.

**Mr McGuinty:** I particularly appreciated your comments about how young people simply cannot fathom what it is they're getting into when they take up smoking. There have been a number of studies done on this. There was one in the States where high school kids were asked how long they anticipated they would continue to smoke and would they stop smoking by a certain age. This was a long-term study and they followed them through. They discovered that almost all of the kids said they would quit by I think it was 25, but when they followed them through, over 80% were still smoking.

I think it's okay to make the comparison with a young child. "Don't touch the hot burner," right? You don't attempt to reason with the child until he reaches a certain age. What the child knows is that if he moves to touch the burner, something the child doesn't like is going to happen. Probably the parent's going to get angry. You prefer that you set up that kind of mechanism where the kid knows, "If I do this, I'm going to get in trouble."

What you're telling me reinforces this idea that there should be a penalty for kids so that they know they're going to get into trouble, not because we can reason with them, but because it's one more thing that'll make it harder for them to get hooked. What do you think about that?

**Ms Klein:** You're advocating a penalty for possession, in other words.

**Mr McGuinty:** Exactly, like we do for alcohol. The doctor made reference to speeding as well. Those things cause damage to you. I think we're underestimating kids'

ability to assume a little bit of responsibility in this regard.

**Ms Klein:** When I speak to young people on smoking, they're very honest. They're very straightforward and very honest. They will say very openly, "I'm not worried about 20 years from now, because it's the here and now." When I'm talking to them about dying of problems or tobacco-related diseases, I'm talking about something way off. Also, they really do believe that we'll come up with something, as they've said, lung transplants, anything. They really take no responsibility for 20 years down the road.

I'm not saying that we don't continue to educate, but there have to be some immediate things that do come to them, and they have to recognize that it is not tolerable. I'm a mother of four teenagers and I know that they do look for restrictions.

**Mr McGuinty:** You have our sympathy.  
1230

**Ms Klein:** Actually it's an enjoyable time because they really make you stand up there and say what you really believe in and then you have to act that way as well. This is where it is with you. What we're showing as a whole society, we're saying one thing and we're allowing and doing something altogether different. The hypocrisy and the mockery that are there are ridiculous. We've really got to stand up there and put our actions where our mouth is.

**The Vice-Chair:** A good note to end on. Thank you very much for your presentation. We appreciate it.  
PAT MADDEN

**Mr Pat Madden:** My name is Pat Madden and I'm the merchandising manager for two Pharma Plus drugstores in North Bay.

I would like to thank the committee for allowing me this time to present my views on the proposed legislation known as Bill 119, and in particular the section of this bill that would prohibit retail pharmacies from selling tobacco products.

Overall, Bill 119 may represent a proper step by government to aid in the creation of a smoke-free society. However, it falls short of proposing a total ban on the sale of tobacco products, and for this reason I would ask this committee to support a change to the section of this bill in which retail pharmacies would be prohibited from such sales. I would ask that it be changed to allow retail pharmacies to decide for themselves whether to trade in a product that would still remain a legal retail product.

While tobacco products are allowed to remain legal, prohibiting their sales at retail pharmacies does not seem to be the proper way to achieve the stronger control or restrictions wanted over them. In the retail sector, the retail pharmacy would be one of the more experienced retail outlets that could exercise such restrictions and controls. After all, our retail pharmacy business has long been equipped with such restrictions and controls of particular or specific items.

Also, given the retail pharmacies' history of following restrictions already in place, such as the sale of tobacco products to minors, I think they have shown an awareness

and an ability to deal with such controls in regard to tobacco.

If this section of the legislation as it is now proposed is to become law, the sales loss to retail pharmacies will unfortunately be significant. In our two stores in North Bay the tobacco sales are approximately 18% of the total retail business. I fear that the loss of these sales will not only hurt our stores' total business by this amount but also have a negative effect on the other areas of our retail business.

Tobacco customers for the most part do not purchase tobacco products as an extra item to their normal drugstore purchases but rather as their primary reason for being a drugstore customer at all. Therefore, extra purchases that they may have made as a result of this will also be lost to our retail business.

I also fear that this loss of business will have a negative effect on the amount of man-hours that retail pharmacies can properly use to be viable in their retail endeavours. At present tobacco sales levels, I would estimate that our stores in North Bay could be affected by a loss of over 100 man-hours per week, or what could translate into the equivalent of two or three full-time positions.

If tobacco products were made illegal in our province, I believe that retail pharmacies would be a strong advocate in aiding the removal of this considered health hazard. However, as long as the tobacco products remain legal, prohibiting their sales in retail pharmacies creates not only an unfairness to a specific sector of the retail industry but also an unfairness that will have no impact on the amount of smoking done in our province, and therefore will not show any health benefit to our public.

The banning from retail pharmacies of products which can be legally purchased within a block of that specific location or even within the same mall, under the same roof, will simply make the tobacco purchasers move their business elsewhere. For us, this can often be more than just their tobacco business.

Finally, I would like to ask this committee to consider this issue apart from the product involved. While there may be good argument for a net gain to society through specific restrictions of products, such restrictions can often infringe on other areas of that society's rights. In this case, the net gain of restricting a specific area of the retail sector from trading in a specific product should be considered in relation to the unfairness of banning a legitimate business from trading in what will remain a legal product. Again I thank you for this time.

**Mr Jim Wilson:** I'm just looking at the only economic study that's been done to date. It was done independently of government, although using the same techniques as those applied by the various ministries in terms of economic studies and forecasts. It was a study done by Coopers and Lybrand presented to the committee last week. You mention job losses. It talks about the total effect on job losses, part-time and full-time, in the province of Ontario. Province-wide they could be 2,746. In northern Ontario—it's the smallest region hit but I assume that's because of the number of pharmacies in the area involved—it amounts to a total job loss of 196. The



government has never come forward with its own economic statement or study, and I think if you're going to tell one section of the retail sector that it can't sell a product, you should at least, in fairness to them, do a study. I want you to comment on that.

Second is something that's in my head from the previous presentation. This study also shows that in fact it'll probably increase the contraband sales. It doesn't go into a great deal of detail on that, other than giving us some indication that contraband or illegal sales of products could very well go up because people don't have access to legitimate retailers in some communities, is the point that's made. Do you want to comment on either of those? Are you familiar with the study?

**Mr Madden:** I am familiar with the study, yes. Your second point, speaking of northern Ontario, may reflect just the number of locations. If you do find yourself in more rural areas, then due to a drugstore not being there, maybe that was Coopers and Lybrand's idea of where to get them at that point. But that's only my opinion. I'm not sure what you meant in the first part of the considerations to comment on.

**Mr Jim Wilson:** I was just following up on your comments about the job losses.

**Mr Madden:** The government study? Yes, I think in all fairness there are a few studies, pro and con, that are circulating around these days if you're within this industry, and they are pro and con. I think it would be probably only fair if the government would try objectively to have one done that would not be pro or con but just faced those economic facts.

1240

**Mr Jim Wilson:** What about the other side of the coin? The government says, "Well, okay, there might be a few job losses." I think there's been acceptance that if you close down the sale of tobacco in the pharmacy sector, there won't be an increase in jobs in the other—how many stores are there?—120,000 retailers that will continue to sell cigarettes because it will be spread over too far a base to actually increase any of the jobs that will be lost in the pharmacy sector.

The government says: "Fine. That's the price to pay for keeping the community of Ontario healthy." At the same time, the determinants of health care tell us that employment is probably one of the best things you can possibly do to keep and have a healthy economy: the infamous Fraser Mustard study that talks about determinants of health care, the most important thing being a healthy economy, a healthy export economy, the second one being to keep people employed. None the less, the government says that doesn't matter in this case even though we spend tons of legislative time dealing with those matters. Any comments on that?

**Mr Madden:** If we believed that it would decrease smoking in the province by eliminating us, I think you'd certainly have more advocates within our industry saying, "Okay, then we'll swallow that loss." But I for one don't see where there is any evidence that smoking will decrease by eliminating us from these sales. Therefore, the issue of the reduction of smoking in our province

doesn't seem to be aided in our restriction.

**Mr O'Connor:** I agree with you that studies can quite often be somewhat biased in how they're presented, and I guess I would question the sample size of the 13.

**Mr Jim Wilson:** It's 13 plus 459.

**Mr O'Connor:** Anyway, I think we have heard from the Addiction Research Foundation that limiting the amount of retailers would have an impact. My question would be, as a retailer, pharmacist—

**Mr Madden:** Retailer.

**Mr O'Connor:** You're a retailer, okay. With Pharma Plus.

**Mr Madden:** Pharma Plus Drugmart.

**Mr O'Connor:** The college of pharmacy has suggested that there be voluntary compliance with some reduction and elimination of the sale of tobacco products. We've certainly heard a varying amount of views on this issue, of course. We've heard from retailers, drugstores, who have said that the way they went about breaking themselves free from the habit of selling tobacco or retailing it was they actually started by taking it from the wall that somebody pointed out to us, that big, fancy wall there displaying it, and put it underneath the counter to start with. They found that the sales, because it wasn't there standing out, dropped off, and then they actually made the move and went away from the sale of tobacco within their retail drugstore.

You're in a retail drugstore and I wondered if you have tried to comply with the college's suggestion that you should eliminate tobacco products from retail drugstores. Did you make any attempts to try to eliminate those sales from your store?

**Mr Madden:** I'm not sure what you want me to answer, but in the reduction of viewing, I think the drugstore industry has—

**Mr O'Connor:** Your store, though. I don't want you to comment on the whole industry.

**Mr Madden:** Because we are part of a corporate chain, we're restricted to what we've been told to do. But as a company and specific stores, I think we have already gone under the counter and reduced the signage and the spectacular wall that you speak of, although if you were a retail store manager, you would know that it's the ugliest area of your store, certainly not the most appealing. Over my career working in drugstores, I've seen its presence decrease at least by half as far as that kind of logo advertising.

**Mr O'Connor:** We heard this morning here in Sudbury of course that 19 out of 38, half of them, don't sell tobacco products. Some of them have made that decision, some never did, and they felt there was no economic impact on that decision from those that had eliminated it.

**Mr Madden:** I think each store is specific, whatever their location was, the time of business and their cigarette business. I don't think you can judge that—

**Mr O'Connor:** Yes. That's why I said here in Sudbury too, knowing you're from North Bay.

**Mrs O'Neill:** Mr Madden, we've been here all

morning listening to various presenters, and the contraband word or even the presence of contraband cigarettes hasn't come up nearly as much, if at all. You've just said something that made me think about it when you said you don't think that your not selling cigarettes will change matters. So that was a hint. But there haven't even been many hints. When we were in southwestern Ontario and certainly in Toronto, this subject came up in almost every presentation. Do you feel there is a strong presence of contraband in North Bay, Sudbury, and the surrounding area?

There seems to be, for instance, a comment made that the lowering of the tax federally yesterday is going to make a big difference here. We didn't hear that as much in the south because people are already getting their cigarettes for \$18 and \$20 a carton. So I just wondered if you could give us an insight since you're from the area.

**Mr Madden:** I do say there is a fairly big part of contraband going on in our city, in North Bay. I saw in Mr Chrétien's talk yesterday in Parliament that 35% was the point mentioned in Ontario for the level of contraband cigarette sales.

**Mrs O'Neill:** That might be an average.

**Mr Madden:** Yes, but I would think that North Bay is not far behind the provincial average in that respect: 35% would seem like it if I look at certain cigarette loss of sales over the last two years. It's just that we in the north usually are a few months behind. The truck takes a little longer to get here.

**Mrs O'Neill:** So you've noticed in your own store a drop in sales that would directly relate.

**Mr Madden:** Yes, that would directly relate to contraband as opposed to they've stopped smoking, yes.

**The Vice-Chair:** Thank you very much for your presentation.

I've tried to equalize the time between the caucuses, and the last speaker did not take as much as time.

**Mr Perruzza:** Given that I hear you stumbling and fumbling, it's okay.

**The Vice-Chair:** There's no problem with that. I've been known to work right through without—thank you for your presentation.

It's been pointed out to me that I must be much more diligent this afternoon in watching my stopwatch. That's necessitated by the fact that a plane leaves Sudbury at a certain time, and those who wish to return should be on that one or stay over. So thank you. We'll try to reconvene at 1:30 sharp if we could, please.

*The committee recessed from 1248 to 1335.*

#### SUDBURY HEART HEALTH COALITION

**The Vice-Chair:** Welcome, ladies and gentlemen. We have many presentations this afternoon, the first being a presentation by representatives of the Sudbury Heart Health Coalition. Welcome.

**Dr Tom Crichton:** I'd like to begin by thanking you and the committee for allowing us the opportunity to speak to you this afternoon. My name is Dr Tom Crichton. I'm a family physician working here in Sudbury. I

am a member of the Heart Health physician team. My colleague with me today, David Courtemanche, is a community development coordinator with Heart Health. We have worked together to co-author this presentation and would both be available to answer questions, should there be any.

To start, just a summary about what Heart Health is, for those of you who don't know. The Sudbury Heart Health project is one of five demonstration sites in Ontario that's been mandated by the Ministry of Health to try to demonstrate to the rest of the province how a community can mobilize itself around the issue of heart disease. We carry a three-pronged approach to this, based on trying to modify three of the modifiable risk factors for cardiovascular disease, namely, better nutrition, increased physical activity and reduced tobacco use and tobacco use prevention. These are the cornerstones of our community mobilization process here in Sudbury.

As a member of the physician team, I focused much of my activity in the last 18 months or so on the tobacco use prevention end of things. We've played an active advocacy role locally on behalf of the coalition in advocating for a stronger local smoking bylaw.

Also, as a representative of the physician team, I have received special training, through a national initiative endorsed by the college of family physicians and the Canadian Medical Association, called Guide Your Patients to a Smoke-Free Future, by which I was trained as a trainer to come back and teach other family doctors to be a more effective advocate in helping their patients stop smoking.

The larger coalition's been involved in a number of other community efforts that we don't have time to go into this afternoon, but there are a couple that are important and I'd like to draw your attention to a few of them. Locally, there is in place a program called This Business Loves Kids. This has been coordinated by Heart Health, the Sudbury and District Health Unit and the regional police department, aimed at tobacco retailers. The purpose of this program was designed to make retailers aware of laws surrounding tobacco and encourage them to comply with these laws.

Heart Health has been involved in an ongoing media campaign attempting to raise public awareness around the health consequences of smoking. Our major focus this year has been a campaign called Code Blue, which involved the production of an action guide available to community leaders to help them organize themselves to take action against tobacco use and heart disease. In this guide are a number of different ideas that have been used in other locales successfully to help teach community leaders what to do around tobacco use prevention.

I mention these programs because I feel they are important, specifically in relation to Bill 119, a bill that I think will have a direct impact on our efforts to help young people stop smoking and prevent them from starting smoking.

In terms of the bill directly, on behalf of Heart Health I'd like to offer our congratulations to the province on your leadership in this area. Bill 119 represents a strong piece of legislation that could have a tremendous impact



on tobacco use in this province. I can't offer any technical expertise on the bill; that's not my field. I would like to give you the perspective of a family physician, though—I do know something about that—and I feel this kind of legislation will impact on my ability as a member of a medical community to deal with this problem.

I think it's important, when we look at the bill, to try to see what is its intent. As I understand it, the intent of the bill is to prevent young people from accessing tobacco products by regulating the way the tobacco products are sold. I think the strength of Bill 119 is found in a few of its major components.

I believe strongly that raising the legal age of purchase of tobacco to 19 is important, because it allows retailers to ask for photo identification, much the way that the Liquor Control Board of Ontario asks for photo identification for the purchase of alcohol.

Furthermore, eliminating vending machines in all public areas is paramount to this strategy. In Sudbury alone, we see vending machines strategically placed in video arcades, bowling alleys, motel lobbies—if you noticed on the way in—anywhere where young people can congregate. Even in the vending machine in this motel, right beside the cigarettes, in the same row, are the Macaroon chocolate bars and the Cadbury Caramilk on the other end. The vending machines being in places where young people congregate gives them easy access to cigarettes.

1340

Banning tobacco sales in pharmacies also is fundamental to an effective strategy here. I gather there was an announcement made easier today that an local pharmacy has been caught selling tobacco to a minor. I think this demonstrates a real need to understand what's going on and who's selling these products. We've heard so much in the last weeks about the black market and how important the black market is. It's not the black market that's the real problem: It's a huge distribution network of legitimate business people who are taking an irresponsible approach, at times, to tobacco sales.

It's incomprehensible to me that we can allow tobacco to be sold in a health care facility such as a pharmacy. It's sending a very poor and powerful message to children that tobacco is associated with health products. It's a mixed message. I've heard people who study this issue and our teenagers say, "Really, if tobacco was all that bad, the government wouldn't allow it to be sold in pharmacies."

Furthermore, I think Bill 119 is an attempt to make health warnings more effective, and packaging in retail stores is important from a public education perspective. I'm impressed that the bill attempts to implement an automatic prohibition against retailers who demonstrate that they'll continually sell tobacco to children. As a community, we recognize that retailers have been given an important trust to sell this product, and if they're not prepared to take that responsibility seriously, we feel it should be the responsibility of public policy to restrict their ability to sell cigarettes.

As I say, I certainly applaud a lot of Bill 119's

attempts to address this tobacco issue, but there are a few components that I think have been omitted, and I'd like to just touch on a couple of those.

First, I think a comprehensive regulatory licensing system is important. With a system like this in place and properly enforced, tobacco retailers would immediately get the message that they can lose their licence to sell tobacco if they're caught breaking the law. I don't know of any other regulatory measure that would be nearly as effective as this one system.

I'd like to see consideration given to plain packaging as a strategy to deal with the tremendous amount of advertising that goes on in the tobacco industry. I have with me today an advertisement from Life magazine in 1946, part of a series that ran. I'll pass it around, and you can all have a look at it. The focus of the article was the number of studies in the 1940s that showed more doctors smoked Camels than any other cigarettes. Camel ran a series of advertisements showing the doctor in a number of different poses and then a statement at the bottom that, "If your doctor smokes Camels, they must indeed be the cigarettes for you." Hopefully, as physicians, we've come a long way since 1946.

**Interjection:** We have.

**Dr Crichton:** Of course it's changed, but advertising is still the same, and that's the whole point of the tobacco industry, to get out there and beat the bushes for more customers.

Patrick O'Sullivan, the executive director of Heart Health, took these photographs locally at a pharmacy to show you just how and where advertising is in place today in this community. I draw your attention to the tobacco advertisements in this particular picture. One is very low, at eye level for kids, and one is up high, close to the sign, and says, "Prescriptions," as if to associate du Maurier with the prescription. This is what's really what's going on in the community.

There was an article about a year and a half ago from the Canadian Medical Association that reported on the success of a huge advertising initiative in the United States. In 1988, Camel had 1% of the teenage smoking market in the United States. It introduced an advertising campaign that included an animated figure named Joe Camel, a cartoon camel who smokes. Within three years, by 1991, Camel's share of the teenage market had increased from less than 1% to 33%. In 1991 a study looked at five- and six-year-old children in California, and the animated character of Joe Camel was recognized by as many of the five- and six-year-olds as recognized Mickey Mouse as an animated character. It's very powerful advertising machinery at work here. But I digress a bit.

The important thing to remember about advertising—you've heard this, I'm sure, before from other people—is that every day in Canada probably around 100 people die from tobacco-related illnesses, so the whole point about the marketing and advertising is that every day the tobacco industry has to recruit at least 100, because they've lost 100 of their best customers in any given day.

We have with us as well a five-pack, a so-called

toddler pack of cigarettes, that Dave had purchased here in Sudbury a couple of months ago. Dave went in to buy this. We wanted to buy 30 packages to give to local politicians at an information night we had. When he asked the clerk behind the counter for 30 packages, she laughed and said, and this is a direct quote: "Why do you want 30 packages? Do you know a lot of kids?" Dave responded with a question: "Why? Do you sell these cigarettes to kids?" Her response was simply to laugh. As the conversation moved on, she was asked where she got the five-packs from, and she said that the same guy who delivers the chocolate bars brought in the kiddie packs of cigarettes. This is really what's happening in the stores: Tobacco is being treated like confectionery candy.

One large area that hasn't been addressed in this bill, one I can bring some personal expertise to, is the area of smoking cessation. We've all heard that Canada has made great strides as a nation in the last 10 years in reducing the numbers of people who smoke. That's great. Unfortunately, what that's left us with is a very hard-core group of committed, addicted smokers. These are people who have tried to quit smoking before or, if they haven't, have really thought about it. They really do want to stop smoking, a good number of them.

The problem then becomes how you can help this committed group of addicted smokers. We're dealing with nicotine addiction, and nicotine has been compared to heroin in terms of its addictive properties. There are people who've been cross-addicted to nicotine and heroin who say it was easier to get off heroin than nicotine.

Studies that have been done in the area of smoking cessation show that if a doctor is interested and expresses interest to his patients, then a higher percentage of his patients will be successful in stopping smoking. It's more than just that, though. The more layers you can add to the smoking cessation effort—the doctor counselling, a nurse counselling, public education, support groups, hotlines—the higher and higher your success rate goes.

Two years ago, when nicotine patches were released, there was a great flurry of interest and activity here about this issue. I did some reading on it. Even with nicotine replacement therapies and good counselling, a good success rate for smoking cessation in a year is 10%—that's good. If I can get 10% of my patients to quit in a year, then I'm doing better than average, which really goes to show you how difficult this addiction is to deal with and break. That is one area that, in a broader sense, we as physicians could use some more help in, in better implementing public education or better policies or community support groups for committed nicotine-addicted smokers who want to quit.

Finally, one other concern about Bill 119 stems from the history of the tobacco industry's dissection of new legislation and its ability to find loopholes in new legislation. It's important, if you can, to try to develop some sort of implementation strategy for this bill such that there can be an ongoing review of the effectiveness of the bill and whether it's continuing to meet what its intent was, and then deal with any attempts by the tobacco industry to move around through the loopholes. I'm not a legal expert, but I would leave that in your hands.

We hear a lot of talk about tobacco being a legal product in Canada now. It is. It concerns me because it really is a legal product only if it's sold legally, and we know that a great deal of time it isn't; not just the black market, but we've heard today that children do buy this product. It's a dangerous legal product as well that I feel has to be regulated.

I think Bill 119 is attempting to do this, and I hope that when you go back to Queen's Park to deliberate over what you've heard here you will remember what the intent of the bill is and ask yourself the question of whether you feel it really will fulfil that intent.

Given our statements, I hope you give further consideration to a comprehensive licensing system, plain packaging, advertising restrictions, and consideration of further help on the issues of smoking cessation.

Thanks very much for your time, and if I or Dave can answer any of your questions, we'd be more than happy.

1350

**Mr McGuinty:** I'm especially interested in any suggestions you might have that would help you as somebody on the front line, or a teacher or parents, help people we have over the course of history tacitly allowed and approved of getting addicted to cigarettes in this province. How do we unhook them? What is it we're not doing now that we could be doing?

**Dr Crichton:** That's a big question, because there are a lot of different reasons different people smoke and are addicted to smoking. You can dissect your population at risk into different groups.

If you begin by addressing those consumers coming into the market at the beginning, if you can somehow restrict their access to tobacco, fewer and fewer of them will start smoking and fewer and fewer of them will be addicted to smoking. Restrictions on selling cigarettes are not going to help adult addicted smokers. They're going to be able to buy this product as long as the product continues to be a legal product in Canada.

If you're asking for my opinion about how to help those people, it's making them ever more aware of the negative health consequences of smoking. It's not that they're not aware; everybody has heard that smoking is bad for you. But people have to hear time and time again, not just from their doctor but from their coworkers and from advertising and from the community at large, that smoking is dangerous to your health, and if you want help, please turn to someplace for help. Whether that's their doctor, a community-sponsored clinic, a support group at their health unit or a hotline they can call, all of these measures would be effective in one degree or another in any different community in this province.

**Mr McGuinty:** Just so I understand, do smokers go through an ongoing process of denial that it's a problem? I assume they all have to do the same thing internally to quit. What is it they have to do before they can quit?

**Dr Crichton:** The first step is wanting to quit. They have to move from what they call the pre-contemplative stage of smoking cessation to the contemplative stage. There are smokers who are in denial, you know: "I won't get lung cancer, I won't have a heart attack. My Uncle



Louis smoked till he was 85, eight packs a day and he's still"—everybody knows somebody like that. A lot of times they will deny, and that's how they put it off and don't even think about smoking. But then one day something happens and they move from never having thought about it to starting to think about it, and that's when you can begin to help them along through making an attempt and staying off.

**The Vice-Chair:** Thank you for your presentation. We're very pleased to have it.

#### PORCUPINE HEALTH UNIT

**Ms Erica Webb:** My name is Erica Webb. I'm the tobacco program coordinator at the Porcupine Health Unit. The Porcupine Health Unit is actually north of here in Timmins. We don't have a large population, but we cover a wide area, up to Moosonee on the coast.

This presentation was put together by the health unit and also by Tobacco Free Timmins Sans Tabac, which is our local Interagency Council on Smoking and Health. They focus their efforts in Timmins, and then the health unit focuses its efforts in the other communities north of us.

We're really concerned about the issue of smoking. The Cochrane district has had significantly higher smoking rates for some time now. In the 1990 health survey, we were 10% higher than the provincial average, and in some age groups we were higher than that.

We don't have data for individual communities, but I can speak from experience, for example in Moosonee, that the smoking rates are very high in the young population. We've done some presentations to grade 8 students up there, and in that class of 20 there was one who didn't smoke. That also might speak to the issue of cost of smoking. For example, there's a native community across the river, and the cost of cigarettes is lower there.

We also have higher rates of lung cancer, bronchitis, emphysema and heart disease within our district. With the increased number of smokers, I feel that secondhand smoke is also a bigger issue: If there are more people smoking, you have more secondhand smoke.

This evidence underscores the fact that for our tobacco use prevention program to achieve our overall objectives in improving community health, we have to have things such as Bill 119. We have lobbied hard in our area. It's probably our first experience with having to lobby on something like this, and it's because we feel we need this bill to back up any educational efforts we have been doing over the past years.

Our local member of Parliament was very supportive in this. He himself is an ex-smoker. It's Mr Gilles Bisson, and he's an NDP member. He's been smoke-free for over a year now, and we've really been able to use him for a role model in the community.

**Mr Wiseman:** He's crankier.

**Ms Webb:** I think he's gained a little weight too.

We're concerned about some of these health issues. One I'd like to focus on is smoke-free spaces. I'm sure you've had some evidence about the dangers of secondhand smoke. It's been classified as a class A cancer-causing substance. We must consider the rights

and health of non-smokers. We've been putting a lot of attention to educating our public about the health hazards of secondhand smoke and trying to make the group that does not smoke more vocal about its rights.

We feel this bill is a good place to start with setting a minimum standard of protection for these non-smokers, especially in communities where the smoking rates are high. Nevertheless, you have people who don't smoke, and you need a minimum standard for those people to be protected from the secondhand smoke.

The issue of smoke-free spaces can also be looked at through youths' eyes. If you have a larger percentage of youths who are not smoking, you can almost look upon the enhancement of smoke-free spaces as a way to reinforce the fact that they are not smoking. If you see a school with a group of students outside it who are smoking and you ask in a class, "What percentage of teenagers do you think smokes?" they will usually give you a figure very much over what the true percentage is. I think the enhancement of smoke-free spaces would be one way to emphasize the positive for students who are not smoking so that you will see groups sitting in smoke-free spaces and setting a positive example.

We've also had some contact from heart patients, asthmatics and the elderly. We have a very active elderly woman who in fact belongs to a non-smokers' rights group in Toronto, and I would suspect she's probably one of the very few northern people who does. She's very active, and her quality of life is definitely affected by the lack of smoke-free spaces.

We have a lot of phone calls from students now who are increasing the number of projects they're doing on secondhand smoke, so there's definitely some interest there from the students.

We have a lot of students who have asthma. They may not smoke, but they are concerned about their asthma and how they can be protected from it.

I also see smoke-free spaces as being important to the process of quitting smoking. When we offer smoking-cessation counselling, one thing we advise people is, for example, "If you're going to go into a restaurant, challenge yourself and sit in the non-smoking area." Well, if they go to a restaurant in Iroquois Falls, there is no non-smoking area, and therefore they don't have any positive reinforcement to do that.

I've also had several calls from a woman who's interested in smoke-free laundromats, which initially may not seem like a real priority, but if you look at the groups of people who are smoking at higher rates they are those who are perhaps less advantaged economically, and these are the people who may be using the laundromats. To emphasize the positive again, if she's in a high-risk group for smoking and she's not smoking, and she's requesting some quality space here, she's right. The only answer I had for her is: "We're working on that bill and we're trying to get that passed for you. I'll have some news for you in a few months."

There's been quite a bit said about access to cigarettes by minors. We feel immediate attention must be paid to teenagers who smoke. I'm a public health nurse, and we

also have other nurses who have counselled those who are trying to quit, adults and youth. It is very difficult, energy-consuming and very overwhelming for some to beat the habit, so prevention is very important. I've counselled some 15- and 16-year-olds who've tried to quit and can't, who fail. I really feel a vicious cycle can begin for these youths when they have such a failure. In addition, today they may be labelled as addicts. These negative experiences are definitely going to cause trouble for them in the future.

One example of that is presentations we've done to such groups as—there's a program called Futures, which is to try to get students who had dropped out of school back into the educational system to upgrade themselves. In those groups, 60% and 70% of them are smoking. Now they're trying to get back into the workplace and they smoke heavily. They've got another problem to overcome.

#### 1400

I met a woman on Monday who had lost her husband, who was a heavy smoker, to kidney and lung cancer when he was 35 years old. She said he had started smoking at 12 years old. Just to put it in perspective, by 35 he had already smoked for 23 years. That's a long time. She had written to our local Lung Association to talk about her experience in the hopes that it would prevent somebody else from starting or from going through what they had. She herself quit cold turkey the day her husband was diagnosed with lung cancer. She was also a heavy smoker.

She said to me that she feels cigarettes should be banned. She stated, "You never think it's going to happen to you." I think we all know that that's where teens are coming from. This scenario is not unique and it's repeated all too often. A strong Bill 119 could assist in preventing the same thing for another 12-year-old. It was interesting that his mother had also died of lung cancer related to smoking, so you're looking at generations. I think licensing would be one way to do that.

The addictive nature of cigarettes is another big health concern which I'm sure you've heard a lot about. We feel this requires serious action. Speaking from my own experience and from other health workers' experience, when we counselled people about the hazards of smoking 10 years ago, we would not very often have been mentioning the word "addiction." Now the words "deadly habit" and "addict" surface very frequently.

The social norms are changing around tobacco use, and I think a process such as this is helping that. If we are to deal with a serious addiction, then we need some serious action. We cannot, for example, compare nicotine addiction to heroin and cocaine addiction in a class in a school and then sit and watch youth continue to smoke where they please.

Even for teenagers who have chosen not to smoke, this is a really big inconsistency, and they'll question you about it when you're doing classes with them. We feel that the regulations around Bill 119 should be very strong and very unconflicting about the social norms for tobacco use.

Some of our recommendations are included in the bill already, and some we would like to see strengthened.

We would like to see the proof of identification raised to 19 years old, and a photo ID is very important. We admit it will not solve all the problems, but it will definitely deter some youths and it will set a system in place. For example, if you deter a 13-year-old who was going to try it, it gives you a couple more years to continue with your educational program.

We feel strongly that a licensing system is very important. It would allow for better monitoring of sales and a method for dealing with infractions, such as the loss of the permit. It sends a strong message to those who sell tobacco. With the example before, the kiddie pack of five, many people who sell tobacco are not aware of the serious nature of this product. I was really disturbed by some of the recent coverage of the debate around lowering taxes on cigarettes. Some people were very excited, as if they were talking about a sale. This is something we should wonder about.

I did hear some talk yesterday when I was listening to the coverage about the administrative load for businesses if there are more forms to fill in and such. Personally, I think that would be well worth it. At the very least, this section should be written in such a way as to enable and encourage municipalities to pursue this channel themselves. I know our local MPP supports that.

Smoke-free spaces: I've already talked about those. We have a small committee in Timmins to look at some changes in our community, and we need the support of the provincial law to back up anything we do there. This should be spelled out specifically to include all areas where teenagers congregate, such as arcades and theatres—someone said to me when we were discussing this that arcade operators may very well support this, as the smoke damages their machines—all sports facilities, arenas and other locations associated with youth and physical activity, again to remove any inconsistencies.

Enclosed shopping malls: We have to remember that a lot of essential services are now located in shopping malls, such as banks, post offices and pharmacies. Elderly people, asthmatics, do have to go into those malls, so it's not a luxury-type thing.

Laundromats I've already talked about.

Reception areas, taxis and restaurants: In our area we're under discussion for 50-50 percentage, not unreasonable when you look at the rates of smokers versus non-smokers. Again, it would give a chance to highlight the non-smoking population in an area for non-smokers.

Plain packaging and countertop displays: It's already been discussed that packaging is a major tool to encourage youths to smoke. We also endorse plain packaging with strong health warnings, and we feel countertop displays should be removed. I think it's been mentioned that the wall of cigarettes with all this nice packaging is very appealing to use.

They should also be located under the counter. There are a lot of other products located under the counter that you have to ask for that are far less damaging than cigarettes. One I can think of, for example, is videos.



They'll leave the package up there for you to choose your video, which is very nicely coloured, but because they don't want the videos shoplifted they put them behind the counter and you have to ask for the actual film. There are other items that the shop owners themselves may feel are in danger of being shoplifted that they'll put behind the counter. I don't think it's unreasonable to ask for a similar approach for cigarettes.

**Removal of tobacco sales from pharmacies:** We feel this should be implemented as soon as possible. There has been a lot of discussion around this. It's definitely an inconsistency and therefore should not continue. There's a lot of money spent by the pharmacy chains marketing themselves as health educators and health providers in order to attract business. Some pharmacies are now marketing themselves as tobacco-free pharmacies. I think that debate should end and they should be removed.

I was struck by the fact that these inconsistencies are picked up by teenagers and younger. I was teaching a grade 6 class on smoking. The topic was not pharmacies and smoking at all, it was just general prevention. A grade 6 child asked me, "If it's so bad, why are pharmacists selling it?" I was totally shocked, totally surprised. Whether he'd been discussing this issue with his parents, I'm not sure, but at grade 6 they are aware of these things. That was an unprompted comment.

In conclusion, the Porcupine Health Unit and Tobacco Free Timmins congratulate the government and members of Parliament for bringing forward this bill. We hope that with the strong input from such things as these hearings, all communities and health professionals, it will assist in achieving the overall health objectives for the people of the Cochrane district and Ontario in tobacco use prevention.

**Ms Sharon Murdock (Sudbury):** I'm very upset with what's happening federally, and I think there's a lot more that can be done.

As to licensing, which is not part of Bill 119 at present but is to be discussed, I gather from your comments that you would have it municipally administered?

**Ms Webb:** That would be a compromise. There are some municipalities that have a licensing system. From what I understand—I'm not totally up on the way the laws can be written—there can be enabling legislation which would encourage municipalities to do that. We have discussed that with our local municipality, and they feel it should be done at the provincial level.

**Ms Murdock:** In Sudbury we have smoke-free arenas and so on, and I gather it isn't the same in Cochrane, if you have restaurants where you can't go—

**Ms Webb:** In the Cochrane district every community is very different. For example, one of our communities in Hearst is largely French-speaking and there's a high rate of smoking up there. Their situation is quite different from, say, Timmins, where I would operate out of. A provincial standard is necessary for such communities even to begin a process.

**Ms Murdock:** Northern Ontario has a higher incidence of smoking rates anyway, compared to the average, and on top of that you have mining, which affects lungs

and so on. If you have communities that don't have no-smoking policies, then you wonder how stringent they would be in terms of enforcement of licences.

**Ms Webb:** I think I said that at the very least it be a municipal licensing system. We feel that a provincial licensing system would be much better. Municipalities like that are very unlikely to undertake a licensing system themselves to begin with, so if you have a provincial system, at some point they would have to do this.

**The Vice-Chair:** Thank you for your presentation.

**Mr O'Connor:** I'd just like to clarify the licensing element. The municipalities do have the ability to license. In fact, many municipalities have it. In the legislation, as far as the municipal bylaws are concerned, where a municipal bylaw is more restrictive than the provincial legislation, the municipal bylaw will have precedence over the provincial legislation.

**Ms Murdock:** So municipalities can have a licensing system now.

**Mr O'Connor:** In fact, some have. I think the city of Vaughan just went to a system.

**Mr Jim Wilson:** Just to clarify that, this act doesn't introduce a licensing system either, so every municipal licensing bylaw would supersede this act, I assume.

**Mr O'Connor:** Yes.

1410

#### SUDBURY BOARD OF EDUCATION

**Mr John Stroyan:** Thank you for allowing us to present before the committee. My name is John Stroyan and I'm the health and safety officer with the Sudbury Board of Education, a board with 56 schools and more than 20,000 students that covers a geographical area more than twice the size of Metropolitan Toronto.

With me today are Tom Bertrm, principal of Lively District Secondary School; Steven Levesque, vice-president of the student council for Lively District Secondary School; Steven Price, a member of our smoking cessation committee for Lively District Secondary School, a smoker himself; and Angela Desjardin, also a member of our smoking cessation committee for Lively District Secondary School and also a smoker.

The Sudbury Board of Education applauds the provincial government for the introduction of Bill 119 and we are anxiously awaiting its passing to assist us in our efforts to reduce smoking among the youth in our communities.

The Sudbury Board of Education has already implemented a plan to eliminate smoking from our school properties. Our plan involves phasing secondary schools into our smoke-free policy. Since the rollout of this plan in January, one school in particular, Lively District Secondary School, has become smoke-free and two other area schools have signed up for the program.

We begin our program with consultation with the students, setting target dates, providing signage, literature and, most importantly, smoking cessation programs for those students. A little aside from my brief: That was done through experience. We experienced student walkouts prior to consultation with the students, so there

was some experience gained in that process.

At the elementary level, through pilot programs offered through the Canadian Heart and Stroke Foundation, Heart Health and public health officials, we will be adopting a Healthy Schools-Healthy Kids program targeted at improving health education for our youth, particularly focusing on heart-healthy issues like smoking.

Unfortunately, in order to make this program a success, we need the support of Bill 119. In particular, there are two areas within the bill that need to be mentioned.

First, under paragraph 2 of section 9, the definition of a school should include the school grounds as per the Education Act, paragraph 1(1)49, which says a "school" ...includes the teachers and other staff members associated with such unit or institution and the lands and premises used in connection therewith."

Second, we are concerned the enforcement of this act will be a low priority for police services. We hope we are wrong in that aspect.

The Sudbury Board of Education is also concerned about the smokers already addicted. We hope this committee will consider provisions for smoking cessation programs for the youth who need the help. It has been our experience that without this offer of help, those students already smoking would just be forced further underground.

In closing, we endorse Bill 119 as a progressive step forward in protecting our children but also encourage the committee to review the few points we have brought forward.

I'd now call upon each of the representatives of the board who are here to make a few comments, and then open up for questions.

**Ms Angela Desjardin:** I feel that this program is needed. The students who are addicted, are addicted. That won't change just by saying, "You can't smoke any more because you're not old enough." I don't think that'll do anything for them. That's basically all I have to say.

**Mr Steven Price:** I think smoking cessation programs would be beneficial, because I feel the same way Angela does. People can't just quit smoking because the law says they have to. They need something to help them out. These cessation programs should be able to help them out if they choose.

**Mr Steven Levesque:** I just have a few quick comments from the student council. I agree with you, sir: Education must begin in the elementary years. Children must be told repeatedly about statistics on health-related problems as a result of smoking.

If you survey the students in our smoking area at Lively high school, you'll find that some, if not all, started because it was a rebellious stage and they started because of their peers. Education can stop the smoking "fad." If this is done, you will not have student walkouts at high schools like ours because students are aware it is wrong. Having schools smoke-free for the new arriving students in grade 9 each year will not be a problem.

**Mr Tom Bertrim:** As the principal of Lively District Secondary School and as a principal with the Sudbury

Board of Education, I have some extremely strong feelings about smoking in schools.

First, I can't understand how educational situations in elementary or secondary school can allow students to smoke on the property or the premises of the building. Smoking is an addiction. We don't allow students to do heroin or to do drugs. It's treated quite seriously.

Second, I have some strong concerns about the model that's shown when we allow students to smoke on the property of the school.

Third, I have some concerns about community ownership for the smoking problem. You can't expect schools to hide the problem and to have designated smoking areas on our property or even the premises. That's not right, as far as I'm concerned, but the public has to share that. If kids leave our school and go and stand in front of a store off the property, I have no control over that. But I feel the community has to have a say in this too. We've had good support involved in that way too.

The last point I feel very strongly about is the fact that students are learners. Also, as the employers of the Sudbury Board of Education, we have to help students and staff members who are addicted to go through a cessation program. We can't just eliminate it; we have to give some support. That's what we're trying to pilot at Lively District Secondary School this year.

1420

**Mr O'Connor:** Terrific presentation. I hope you don't mind if I share this with some high schools in my riding. Just one correction to item (f): Under the law it's 18, not 16.

**Mr Stroyan:** I'm sorry, that's an error.

**Mr O'Connor:** I'll correct that when I share this. The other thing is: Under section 9, paragraph 2, you talked about the "school" definition. Actually, the intent is to have the legislation—though it doesn't say that; I guess we'll have to clarify it—use "school" as it is written in the Education Act. That's what we had planned, but we need to clarify that and get legislative counsel to draft it so the intent reads the way you put forward.

**Mr McGuinty:** I'm going to touch on two areas. I'm very interested that you said you had a school walkout because the program was, I gather, put into place overnight. The other thing I wanted to get a bit more information on was the cessation program that's offered at the school. Would you suggest that we phase this in, or what's going to happen in our high schools if we say, "Look, folks, tomorrow, bingo, that's it: no smoking?"

**Mr Bertrim:** The first part of the question centres on learning how to do something. This is a complex issue. We had a non-smoking policy on the property and premises at our school for two years before, but it was a farce because we didn't supervise it. It became even more farcical when our students who are smokers became very casual about how they were smoking in designated areas. I asked my teaching staff to come on board and we did supervise it and we asked people to leave the property if they wanted to smoke. We had a walkout one day, but as far as I'm concerned, it was probably the best thing that ever happened. Because of that, we had a committee form



in the school and we started to do things the right way. We've engaged a committee that has smokers on it, student council representatives, staff members, and we're back on the right track.

With regard to the smoking cessation programs, we feel that without offering that assistance to the students, they wouldn't participate in the program. One of the things I was very disappointed about as we started to explore smoking cessation programs was, first and foremost, that there are no programs within our community geared to youth. That was a real challenge, to get smoking cessation programs for them. We have been able to work with one organization that itself is running it as a pilot within its organization, the Seventh-Day Adventists' program, but the services were not available for the youth.

We feel it should be included in the bill for those who are already addicted, because it is an addiction, and that it should be phased into the schools—that is the learning we have gained—over a period of time, whether it be the grace period of the act or whatever, when it does pass, and that the services be offered to the existing students, and not just cutting them down cold turkey.

**Mr Bertrim:** As an addendum to what was just said by I believe Angela, several of our students have mentioned the power of peer pressure. What we are trying to do in Lively is offer a program which will begin the Monday after the March break, and it has the same basis some industries have offered. We are offering to our students, as a part of the regular school day, a 10-hour program where, when they are onsite in school, they can go and take the cessation program. It's kind of like it has a credit base or a monetary base. Our board is even allowing any teachers or support staff who wish to take this course during the course of the school day; they won't lose money or anything like that.

The other thing we've done is that as we've formed our committee—and this is from some of the research we gained from British Columbia; I researched Canada when it comes to how these programs go. We're taking a senior student approach to this and we're starting off with the seniors in the school who are smokers and want to quit. We hope then to get a peer basis and move from that as models to the rest of the school over the course of the next several years.

**Mr Wiseman:** Are you going to extend it to the elementary schools too?

**Mr Bertrim:** In our area of Walden that's probably an even more important area. It's my dream that all elementary and secondary schools will have a completely smoke-free philosophy.

**Mr Stroyan:** We currently enforce a smoke-free property in all of our elementary schools, so the secondary schools were our primary focus because that's where we had designated smoking areas. The elementary schools are already smoke-free property.

**The Vice-Chair:** Thank you very much for your presentation and for bringing the students with you. We deeply appreciate that. The best of luck in your program. We hope it'll bring results.

#### SUDBURY AND DISTRICT HEALTH UNIT

**Ms Laurie Fraser:** My name is Laurie Fraser. I'm a public health nurse at the Sudbury and District Health Unit. I'd like to introduce Vic Sahai, our epidemiologist in our teaching health unit, and Noella Piquette, a senior citizen in Sudbury.

The Sudbury and District Health Unit would like to commend the NDP government for its leadership in bringing in Bill 119. This law could set national and international precedents. I'm sure the world is watching.

The Tobacco Control Act could lead to major breakthroughs for the regulation of environmental tobacco smoke, or ETS. This could mean protection from ETS for all non-smokers. We must remember that the majority of Canadians are not smokers. Sometimes it seems to get lost in the shuffle.

Bill 119 would also prevent the tobacco industry from accessing our children as it focuses on hooking a new generation of smokers. This bill as it is, is a good start, but we could do more. Areas like workplace environmental tobacco smoke, banning the sale of chewing tobacco, which is becoming a popular habit with our youngsters as they look at their favourite ball players and other hockey heroes, a licensing scheme for the regulation of tobacco retailers, and the investigation of the tobacco industry's role in the smuggling issue indeed require closer investigation.

I'd ask Vic Sahai to highlight tobacco issues in light of the Sudbury experience.

**Mr Vic Sahai:** I would like to ask one question. If tobacco were a germ, or if we were dealing with handguns that were killing 39,000 Canadians a year, this wouldn't go on. You would do something about it immediately. I know you've seen the stats. I think you've seen them so many times that they just go right over your head and you say, "Yes, we have heard the stats." But I would like to put these stats into context. If tobacco were a germ, as Canadians, as citizens of the world, we would be in crisis.

Look at the third page, where it says "If Tobacco Was a Germ." The third point is that tobacco kills 45 times more people than AIDS, yet as a government in Canada we spent \$100 million last year on AIDS research alone.

Also, in terms of secondhand smoke, if I were to go to a pharmacy and buy a handgun and then take it to a restaurant, I would be locked up. Tobacco smoke, especially secondary smoke, kills a lot more people in Canada than handguns. So please don't tell me that we do not have a crisis in Ontario, in Canada, in the world.

This isn't my show. I would like to introduce Noella 1430

**Ms Noella Piquette:** Ladies and gentlemen, members of the committee, I thank you for hearing me. I'm a senior citizen and I live in a senior citizens' building. I would call that a public place that deserves to have eliminated the smoking in the lobby on the first floor. The smokers are in the minority, but they spend all their time downstairs. They don't have too much to do, so the cigarette takes the place.

I've been in four buildings in 13 years and I had no

problems in my lungs and my heart. Now I'm on oxygen until the day I die and I bleed from the lungs. I was hospitalized last February, a year ago. I spent 29 days in the hospital, bleeding constantly. Two weeks ago I had a nosebleed like a haemorrhage; all of a sudden I was just splashed. My throat has been itchy, because I had a tumour and they took half my throat, and paralysed, so if I cough, it's hard, and something breaks.

There's a small lobby and a small laundry room and there's only a wall between the two, so they do their washing and then they come and sit in the lobby, five chairs and they get some from the rec rooms, and they smoke in the rec room, so the smokers have the run of the house. So we, the non-smokers, who are the majority, don't dare say anything, because the smokers are on their guard and they're not going to give up easily.

They told one gentleman of Ontario Housing, the first meeting we've had at Towers, "I'm not going to go outside and smoke." The gentleman asked, "What could we do to make the senior citizens live better and longer and be satisfied?" I told the gentleman—I forget his name—"Smoking would be the first one." I'm having oxygen 24 hours a day, as soon as I get home. I don't go out with it, because it's a nuisance to go out. I haven't washed my clothes in the laundromat for two years since I've been there, because the smoke's there and I just choke. The others are afraid to say anything, but they're behind me.

I've said I'm on oxygen, and I'm on nitroglycerine, three patches a day, for my heart. I've got a cardiac heart and one lung that gives me a lot of trouble. I'd like to see the smoke disappear from the first floor and the halls to the top of the building, with signs and posters put up, because they won't listen to anything else but strength or orders, so I don't say anything to them.

But I mentioned it in church. The priest came in and said the mass on Sunday, and he was looking at the poster on the wall: "Did you walk a block today?" The priest said: "Yes. Did you walk a block? That's good for you." I said: "Well, they forgot one thing. What about the smoke down here? It's so thick you can cut it with a knife. I don't know how long I can take it without them putting me six feet under." He said, "Yes, the smoke."

I'd like to have that disappear. There are a lot of them who don't say anything and just whisper. I've got 27 names gathered already just since I read about the health unit in the paper, Northern Life, and I phoned Laurie. I didn't know her, but we got to know each other. We pay the same rent, but we are in jail. There's one woman who smokes night and day, just chain-smokes; she lights them all almost with one match, and then she opens her door and here the smoke comes out. I have to open my patio door. They've also got a patio door and windows, so they could smoke in their apartments; I don't mean to cut them off. But the rest of the building is all ours, not just for them.

That's about all. Thank you for hearing me, and I hope something can be done to erase that smoke once and for all.

**Ms Fraser:** The health unit aim is to improve the health of the total population, specifically in the area of

tobacco, to improve the health of the population by eliminating tobacco use. It is through this kind of legislation that this goal will happen.

We have run two successful Quit and Win campaigns for smokers in the Sudbury area, in 1992 and 1993, and have just completed a telephone information line for Sudburians who wanted help to quit during National Non-Smoking Week. We have talked to hundreds of smokers who are battling to break free. They're asking for supportive environments to aid them in their struggle to break free. They want support from the people in their families, support from the people in their workplaces, and support from their communities. Other people have a role to play, and I think this is an area that is often not considered by other people.

It's easy to forget that these issues do not refer to faceless statistics but to people struggling out there with tobacco issues, people like Noella. We want to thank Noella so much for sharing her personal experiences with us. The government has pledged to cut cigarette consumption in half by the year 2000 and to reduce the annual toll of 13,000 people who die prematurely because of tobacco use. For Noella and all the others like Noella, let's get on with making it happen.

**Mr Jim Wilson:** Noella, you make a very compelling case with respect to the building you live in. I'm going to give the government the opportunity to clarify this issue. While I agree with the health unit's comments that this bill will help with some of the secondhand smoke, environmental smoke, I'm not sure we're doing anything for your case, Noella. I'll let the parliamentary assistant explain the government's position on that.

**Mr O'Connor:** Thank you, Jim, for the opportunity. I appreciate you coming. Part of the overall government strategy you've talked about. It works out to about 5% a year reduction. I think that, with all the work from all the communities, is achievable.

The issue you pointed out, that's why we're having the public hearings. In the bill we've stated "and other public places" to allow us the opportunity to spell out places in the regulations, so it's important that we do hear from people. We've heard suggestions that there be a total ban in all public places and we've heard from people saying places like laundromats, arcades and what not, and from yourself about the public places in apartment buildings. It's important that we hear from people like you, and that's why we're having the public hearings. It's possible for us to do that, because we have the ability through this legislation.

It's important that people like you do come forward. I appreciate you taking the time to come here. I'm sure on a cold day it's probably awkward for you to get out as well.

**Ms Piquette:** It's tough, yes.

**The Vice-Chair:** Thank you very much for your presentation. We were very pleased to have you today.

**Mr Jim Wilson:** I just want to know from ministry staff, under this act, what is the legal status of an apartment building like the one Noella lives in? Is it possible to incorporate it under this act, or is there some other act



we have to look at? Is it considered a public place?

**Ms Mitchell:** Are you talking about apartment buildings or public housing? I'd want to look into it and get back to you.

**Mr McGuinty:** Are they covered under Bill 119?

**Ms Mitchell:** No, because it's not one of the premises specified within the act.

**Mr Jim Wilson:** Is it possible under a health act? I don't want to mislead the witnesses that we can do it as an amendment under this act if we can't do it under this act.

**Ms Mitchell:** Could we have the opportunity to consult legal counsel and get back to you later?

**The Vice-Chair:** Absolutely.

1440

#### FRESH

**Mr Gil Gasparini:** Hello. My name's Gil Gasparini, and this is my daughter Katie. We're here representing FRESH, which stands for For Reduced Environmental Smoke Hazards.

It's great that the government and you people in general would take the time and the effort to tackle this very important issue. I'd like to do a little background on myself, just to show you where I came from in the smoking issue.

I've never been a smoker. I probably tried it when I was very young, but I always disliked it from as far back as I can remember. Right now, I'm a parent with four pre-teen children. I've looked at this issue and I've said we've got to do something so that my kids aren't affected, dragged into the whole spirit of smoking and thinking it's cool and thinking it's sexy.

My wife and I have both taken a stand. We've made our home smoke-free, and I don't make any exceptions for anybody. My mother's a smoker, and I won't let her in my house to smoke. When we go to restaurants we insist on non-smoking sections. It irked me to no end when you used to go into a restaurant and they would tell you, "We've got something in non-smoking if you want to wait." I've walked out of restaurants when they say that. That was a stand I took.

We joined FRESH, which was established when the city was making its bylaw. We wanted to have some input to make sure it was strong legislation. We've worked with Katie's school to make posters so it would have an effect on her and would also have an effect on the community. We write letters to the newspaper when someone says something in the paper that I feel is stupid. My wife is sitting now on the Sudbury and District Council on Tobacco or Health. We take every opportunity to talk to our kids about the dangers of smoking.

What really bugs me the most is that even after doing all this, there is still no guarantee that my children will not be dragged into the smoking issue. What I'm looking for from the government and in legislation is, to use a phrase of the 1990s, a paradigm shift, where the attitudes are changed so that people will not go into laundromats, will not go into restaurants, will not even go into hotels and think they have a right to smoke.

I watched a movie the other night where a lawyer was asking questions of someone on the stand and he was smoking while he was doing it. A lawyer would not do that. He wouldn't even think of doing that. People coming into the courthouse would not even think that was allowable. I want that same attitude to be prevalent in society, where they don't think they have the right to go into a restaurant or a hotel and light up a cigarette.

Getting involved with FRESH, I found out even more of the dangers of secondhand smoke. I'm not going to list all the things I've heard; you've got all the material in front of you and you know what it's all about.

We'd like to see this legislation strong. We like to think of it as the pointed end of a wedge. This is only the beginning. We'll just keep going until we're a smoke-free society.

We would like to see plain packaging with much stronger warnings on it so that it sends a signal. These are dangerous chemicals you're inhaling, and we would like to see that warning. The packages are acting as the advertising for tobacco right now. I was at a coffee shop, and this young person took out one of these little tin packs that flipped up that were sold by the tobacco industry, bringing back that sexy image, something different. I hear they couldn't keep them on the shelves at Christmastime; they were sold out like crazy. That has got to stop. The whole packaging issue has got to stop so that the cool and the sexy image is gone.

I've got written down here banning the kiddie packs. I hope the federal government has now addressed that and they'll be gone.

**Mr Wiseman:** They're looking at it.

**Mr Gasparini:** Not yet?

**Mr O'Connor:** All they said is that they're looking at it.

**Mr Gasparini:** I hope this legislation will have something in it.

I'd like to see the age raised to 19, as a lot of people have mentioned before. I'd like to see a strong licensing of retailers, that when they don't comply they get a big fine and if they keep non-complying they lose their licence.

I was just watching—I don't know if it was these proceedings last night on TV. The thought came to me that we have liquor stores that are already licensed establishments. I know there would be an outcry of many confectioneries and many stores, but if a confectionery store is dealing with one product to handle its whole load of making an income, it's in trouble to begin with.

I don't know about this last point. We put down that vending machines should be banned. Sudbury I believe has banned them. I don't know if it's across the province, but—

**Interjection:** They're banned in the bill.

**Mr Gasparini:** It's banned in the bill? That's great.

The last thing is the change in attitude. I'm hoping that this change of attitude is pushed by the government. I don't think it's going to happen on its own. It's got to have a driving force. I think Bill 119 is a starting edge.

Hopefully, it will be, and my children, as they become teenagers, will not be in that predicament of having to fall under the pressure to start smoking. Thank you.

I'd like to present my daughter. She wants to say a few words.

**Ms Katie Gasparini:** Hello. My name is Katie Gasparini. I'm an 11-year-old who's concerned about smoking in my generation. I live in a non-smoking house and have great influence from my parents, and I hope never to smoke. But normal children have that opportunity. For instance, one girl I know whose mother smokes told me, "It's no big deal; we're all going to try smoking once or twice," and what that girl says, lots of other girls listen to. That's what I want to stop, things like kiddie packs. No heavily addicted smoker is going to buy a pack of 15 cigarettes. A 12- or 13-year-old will, something they can afford.

We made drugs like crack illegal. Why can't we do that for cigarettes? Then thousands of people don't have to die; for instance, my friend's grandmother, who died, or my grandmother, whom I worry a lot about.

But do you know what really won't stop smoking? All those movies that had a hero smoking, and it's not usually an ugly person. It's usually a pretty blonde girl or a handsome muscular boy whom everybody likes. I agree with thousands of people. Those movies and shows have to be banned. And you know the commercials supported by the government? I know it's for a good cause, but if you have a body like that—skinny, blonde and pretty, or tall, handsome and muscular—maybe it's worth jumping into a pool of harmful chemicals.

If you reduce the taxes, children will be able to buy cheap cigarettes. Canada will have half the children smoking. We, my generation, need your help. You could help us by educating children, getting rid of kiddie packs, making cigarettes illegal, banning those shows and movies with the pretty girl who smokes, and looking at all situations before putting them on the air.

Do you care about me, my friends and my generation? If you do, you know you need to help. Thank you.

**Mr O'Connor:** You talk about this being a wedge. There might be a few things the committee disagrees over—that's part of partisan politics—but we agree we're just part of that wedge; that the other parts of the wedge are people like yourselves who are actually out there in the community supporting the associations that have been around for quite a while working on these issues, like Heart and Stroke, and the lung and cancer societies, and people like you coming forward in the next generation of supporters trying to change this attitude.

When you talk about this being part of the wedge, you're right: It's only part of it, and there's been other legislation in the past. Legislators can't do it alone. We'll try to do our part, and we appreciate your coming forward and being the other part of the wedge.

**Mr Wiseman:** Katie, you saw the presentation by the previous group from the Lively high school. If those young people were to come into your school and make a presentation, or talk to you and your friends, what kind of impact do you think that would have? Would that be

important? Would that help? Would that have an impact on that girlfriend of yours who sees smoking in her house on a regular basis, or is she already too far influenced by her parents?

**Ms Gasparini:** We're not really friends, she doesn't listen to much I say, but I think it would make a big impact on most of my friends who do like me.

**Mr Wiseman:** So if these two young people from the Lively high school who were here, who smoke but want to quit, came around to your school and said they smoke but that they want to quit and why, and that they shouldn't start, that would have an impact?

**Ms Gasparini:** Yes, probably.

**Mr Wiseman:** Good luck.

**The Vice-Chair:** Thank you very much for your presentation. It was very helpful.

1450

SABIH UDDIN

**The Vice-Chair:** The next presentation is from a representative of Dean's Pharmacy. Welcome.

**Mr Sabih Uddin:** Good thing the roads were great for coming from North Bay.

**Mr O'Connor:** I could have seen my grandmother if we did.

**Mr Uddin:** Mr Chairman, members of the standing committee on social development, it's my privilege to be here from North Bay to present my views in support of the Tobacco Control Act, Bill 119, and make suggestions for improvement of this bill.

My name is Sabih Uddin. I'm a community pharmacist. I have owned and operated an independent pharmacy in North Bay since 1974. I'm proud to say that I voluntarily never sold cigarettes in my pharmacy and I still have survived.

I am an active member of the Ontario Pharmacists' Association and the Canadian Pharmaceutical Association. I was a member of the council of the Ontario College of Pharmacists from district 14. I served on the council for about five years. I was a member of the council of the Ontario College of Pharmacists, which passed a resolution in 1990 to eliminate the sale of tobacco from pharmacies. So I've been involved with this issue for quite some time.

I would like to congratulate this government for acting responsibly by introducing Bill 119. I also applaud the opposition parties for their support of this bill.

There is no doubt or controversy that tobacco use is the most important public health problem in Ontario. It not only is directly responsible for about 13,000 deaths per year in Ontario but is also a major contributor in producing a number of diseases, including ill effects on the foetus of the parents who smoke, both mother and father. At this time I will not elaborate on the adverse effects of tobacco on the human body. I am sure members of this committee are all well aware of the health problems caused by tobacco use.

Tobacco is highly addictive and is also a lethal product. Ironically, most children start smoking between the ages of 12 and 14 years of age. Health and Welfare Canada surveys show that over 90% of young smokers



started before the age of 17. I'm quite pleased with the provisions of Bill 119 which directly affect young people's ability to gain access to tobacco products, in particular the provisions which: tighten control on the sale to minors; raise the minimum age to 19 years for a person to buy tobacco products; reduce tobacco outlets for young and old alike by imposing a ban on vending machines; ban tobacco sales by health care professionals and establishments, especially pharmacies; impose tougher guidelines for packaging and restrict advertising of tobacco; prohibit smoking in designated places, including schools; and set mechanisms and penalties for non-compliance.

Bill 119 can be improved in several important ways.

The Tobacco Control Act should have a clear definition of a pharmacy. It should specify limitation of the signs at the point of a retail sale. It should also define school grounds and require a usage report from tobacco wholesalers and retailers, just to keep track of where the things are moving.

The term "pharmacy" is not well defined in Bill 119. Compounding this problem, the definition of the term "retail establishment" does not unambiguously and clearly prevent direct, exclusive access between pharmacies and areas devoted to tobacco sales. To resolve this problem, I propose the following definition of the term "pharmacy":

"Premises in or in part of which prescriptions are compounded and dispensed for the public or drugs are sold by retail, as well as all contiguous retail space, whether under common ownership or otherwise, within the premises and whether used for sale of health products or otherwise."

I feel a clear definition of pharmacy is extremely important. Only then will all pharmacies, large or small, in supermarkets or department stores be on the same level playing field.

I also feel that cigarette packs of less than 20 cigarettes should be banned, which has been previously mentioned. As I speak, they sell kiddie packs.

The time exemption for implementation of the pharmacy ban should be reduced. Had the government acted when the college passed the resolution in 1990, no pharmacy would be selling tobacco by now. The time has been given to all the pharmacies already.

Under section 15, a 12-month sale prohibition for a third or subsequent conviction should be specified.

Section 9 should be amended so as to prohibit smoking in all public places unless specifically exempted by the act or its regulations, and we need to ban spitting tobacco.

There are two other important issues which are not directly addressed in this bill but which need attention by the Legislature. The first and most urgent is the need for further controls on smoking in the workplace. The second is the issue of retailer licensing.

I would like to see licensed establishments which handle tobacco products, whether retailer, wholesaler or manufacturer, bear all the cost of implementation of this act. The fee for the licence should be specified and

periodically revised to meet the increased cost of implementation.

I believe the incorporation of the above amendments into the Tobacco Control Act will create a world precedent. Passage of this bill will be in line with the government's commitment to preventive health care as a reality. Strong support for an amended bill will indicate to the Legislature that the political leadership of this province is serious in its desire to keep our young people away from tobacco industry products and ultimately have a smoke-free generation, which is the desire of all parties who are in support of this bill.

I also feel the elimination of tobacco sale from the pharmacy would not have an adverse effect on the economics of the pharmacies. It has been tried. I've never sold it. I know how it can be done. Many of the pharmacies have done it without a great deal of hardship.

**1500**

**Ms Murdock:** We had a couple of presentations made in Toronto last week from pharmacists who claimed that the retail side of their business was going to be dramatically affected by taking cigarettes out of their sales. Our point is that if you're a health care professional, you can't be talking out of both sides of your mouth; you either are a health care professional and you don't serve noxious poisons to all and sundry who come in. I'll fight to the death on that one.

But your definition, at least as I'm reading it—and maybe you didn't intend this; I don't know—for example, in Sudbury here, K mart up at the Four Corners has cigarettes at the cashier as you go out. So under "all contiguous retail space," that would be affected. You said, "whether under common ownership or otherwise," which would also mean the mall hall. Am I correct in understanding that?

**Mr Uddin:** It wouldn't be contiguous as long as it was in the same framework of the store. If that particular store, K mart, decided to have a pharmacy, they have to meet certain standards of keeping the pharmacy. They can keep the tobacco outside, like a kiosk, not within the same premises of the four walls of the store. That would be my answer to that. And supermarkets have an option: They can sell tobacco, they can sell whatever they want, but if they want to sell tobacco and have a pharmacy, that's no good.

**Ms Murdock:** I agree.

**Mr Jim Wilson:** Given that Ms Murdock made the point that pharmacists can't talk out of both side of their mouth, using the same logic, can the government talk out of both sides of its mouth? It makes a huge profit out of tobacco, some \$800 million a year, and Mr Laughren's made it very clear he does not want to give up the revenue. In his first week of discussions about lowering the tax, it was not health reasons he was citing. He can't afford to give up \$800 million to \$1 billion worth of revenue. So this is the first government in history to say, "Health professionals can't make money off tobacco, even if they are retailers, but we can, because we're the government and we have a monopoly on this sort of thing."

**Ms Murdock:** Because we're paying \$17 billion in health care. That's why.

**Mr Jim Wilson:** Either you apply logic or you don't, in my view, and that's why no other government has singled out pharmacists, because we're more guilty than the pharmacists could ever possibly be. We didn't do that, because we apply logic.

**Mr Uddin:** I agree with you that there are two sides of the coin, that it is very difficult for the government to lose the control of the \$800 million or so it collects in terms of the revenues. But as the honourable Sharon Murdock mentioned, there is a lot more money spent on treating those than the tax revenues they're responsible for.

I'm in favour of even higher taxes, but I can't seem to get anywhere. I think it should be such an expensive item. The people who smoke are the ones who should pay for it. On the other side of the health issue, those who smoke should have to pay an OHIP premium maybe 10 times higher, whatever it may be. If the government reduces the taxes: "I'm going to reduce \$5 of tax. If you smoke, next time your OHIP bill is going to be so much more. I'm going to charge you more for the OHIP."

**Mr Jim Wilson:** That's a good idea. That's what private insurance companies do.

**Mr Uddin:** Private insurance companies do it. I think the government should look at it at this point. You're starting to hear talk about the federal government reducing the taxes because we are all wondering about smuggling and what not. "All right, fine, we'll reduce the tax by \$5, \$10," whatever it may be, "but if you smoke, we're going to have to charge you for your health bill." That's something to look at. Maybe I've strayed out of my main frame.

**Ms Murdock:** Do the pharmacies in the country you came from sell tobacco?

**Mr Uddin:** Some did, some did not. But I never sold it, and "voluntarily" was the word I used. When I bought that store, that store did sell tobacco. The very first thing I did is eliminate it, and in the space it was in I concentrated on other health products, diabetic and what not, and I had more people coming to me ultimately. Basically, if the pharmacists want to, they can concentrate on providing health services in other areas, not just the filling of the prescriptions alone. That's the way I feel.

**The Vice-Chair:** Thank you for the presentation and answering the questions we had.

#### SUDBURY AND DISTRICT COUNCIL ON TOBACCO OR HEALTH

**Ms Claire McChesney:** My name's Claire McChesney. I'm the chairperson for the Sudbury and District Council on Tobacco or Health. I make that distinction, because we feel those two words are mutually exclusive, that you can't have them both; you have one or the other. I would also like to introduce Marjorie Shaw, who's a registered nurse at the Northeastern Ontario Regional Cancer Centre and a colleague of mine.

You have some printed material before you. I have to preface my remarks with the fact that this has changed at least four times over the last 24 hours and I reserve the

right to say it's my cheat sheet. That's really all it is.

I'd like to start by congratulating the NDP government particularly for resisting the stampede right now to lower the tax. That's the most catastrophic thing that could have happened to us in health care in relation to the tobacco question. I would like to change what I said following that, that I hoped the opposition parties would join the present government in supporting Bill 119, because it's obvious from what's going on here today that there certainly is support, because it is a non-partisan issue. Health, as far as I'm concerned—

#### *Interjections.*

**Ms McChesney:** No yelling across the table.

**The Vice-Chair:** Thank you. I need the help.

**Mrs Cunningham:** It's been one of those days. We got up early.

**Ms McChesney:** They tell me that travelling up north, the air is a little more rarefied.

In light of what has happened at the federal level, it makes the passage of this bill so important. I can't underscore that enough. Not only is it important that it be passed, but it's important that it be passed now, not five, six, seven, eight months down the road. We need it now because the floodgates are open. Whether we like it or not, they're there.

One of the reasons you haven't heard a whole lot about the whole issue of contraband, our feeling is, is that that's a red herring. The tobacco companies have done it beautifully. They're laughing all the way to the bank. You won't hear anything more from me on that subject.

Our objective, really, is that the whole thing is about kids. We've got to keep them from starting. You heard young people coming here today and telling you just that. How are we going to do that? There are a number of avenues we can take, not the least of which is plain packaging. The feds have said, "We're going to look at it." That's not good enough. You don't have time to look at it. Get off your duffs and do something and do something now. If you've got children, you know they don't buy generic jeans. Mine didn't, and I don't think any of yours do. That's a no-no; it's got to be the brand name. So put them in the plain brown wrapper. It's a help. Everything is a help.

**Mr Wiseman:** With dirty lungs on the front.

**Ms McChesney:** Exactly, the dirty lungs on the front. I like the idea of them being just plain white with a big black bordered thing that says, "Tobacco kills." It says it all very simply.

**Ms Murdock:** Hard to smuggle, too.

**Ms McChesney:** Yes. We have to be careful in our deliberations. As I mentioned before, don't get swung by the red herrings. Watch the loopholes, and there are loopholes. This is where I'm talking about it being a non-partisan issue. Don't get caught up in the loopholes; close them. The one that comes to mind most readily—I think it's under 3.2—is where they're talking about selling or giving to persons under 19. The Liquor Control Act covers it very nicely. Don't reinvent the wheel. Just take that. It's there for you. Just follow the same logic. It



covers it very nicely. We talk about the legislation. You're quite right when you say government is trying to do its part. It's about time, I'm glad you are, but I agree it is multifocal. It's not just government. Government plays, though, a very important part, there's no doubt about that. Our communities, with our municipal bylaws—and we're extremely active in this community in relation to municipal bylaws—have our role to play. I as an individual have a role to play as well. It's when you put all three of those in synchrony that you're going to get the results you want. But we've got to work together, we can't be pulling in two different directions. I agree we've all got a role to play. You do yours and, by God, I'll do mine. There's no doubt about that.

We could sit here and you could come up with the most fantastic Bill 119 that would even please me, but if nobody enforces it, we might as well all pack our bags and go home because it ain't worth the paper it's written on.

Just to prove a point to you, we had our little session at noon because, as a council, we decided before we started our presentation that we wanted to know what was happening right here in our community, because none of us smoked and you can really get out of it. So we counselled a 16-year-old to go into a Shoppers Drug Mart—this was with parental consent, by the way—to buy a pack of cigarettes. First try, boom, got his cigarettes and walked out. Now, this is not somebody who looked 18; he was 16. He's two years below age. Wasn't asked for ID, nothing: first crack. Somebody said, "Did you try anything more?" We didn't need to. That said it all.

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To get back to the issue of the red herrings, forget the contraband. They don't need to get contraband cigarettes. They can get all they want in the local store, at the pharmacies, the gas bars, wherever. Contraband in terms of our youth really is not an issue.

Going back to enforcement, it's been proven in the States that you can educate till the cows come home, you can go to them and say, "This is bad for our children. Don't do it. You must be civic-minded" etc, and they will say, "Yes, yes, yes," and they will continue to sell to the minor. You need a sting operation and then you need somebody to walk in afterwards and say, "This is the first time. The second time, you lose your licence" or "You can't sell your products" for whatever length of time. That is far more difficult. I spoke to a retailer about that, and it's much more difficult for them to have their customers come in and have to say to them, "Sorry, I can't sell you cigarettes today because I broke the law and I'm not allowed to." Not only is that an embarrassment for them; the other thing that happens is that the customer who came in for cigarettes is going to go to the place across the way: "I can get my cigarettes. I can do the one-stop shopping." We have to enforce it. It's no good if you don't enforce it.

In terms of the pharmacies, because I'm in the health care field is why I feel so strongly about it. They can't say, "I'm a health care professional, but I'm going to continue to sell cigarettes." You get cigarettes at this end and you've got the nicotine patches under lock and key

at the other. It just does not compute. We're sending the wrong message, and that's the difficulty I have with the pharmacies selling cigarettes. It has nothing to do with retailing, who's going to have a job and who isn't. I'm here to protect the kids, and that's the message you're sending them. We can't do that. We can't afford to do it.

I don't think it's any more correct for those cigarettes to be sold in that pharmacy than in a tuck shop in the hospital. I feel that very strongly. I happened to be a board member of the Sudbury General at the time, and believe me, that one was debated. That was at least eight or 10 years ago, and we debated that one till midnight and it won by one vote. So it was not easy.

This brings me to my closing remarks, and that's about addiction. We've discussed today that maybe we should penalize the youngsters who are caught smoking. I'm not taking issue with that, but the one thing we really didn't talk about was the real culprits: It's the tobacco industry, and the buggers are getting away with it. Who the heck is penalizing them? They're protected. They're protected every which way and back again. One of the things they have just done magnificently well is to conceal the fact of addiction. We know that nicotine is as addictive as heroin or cocaine, but you can walk out and speak to young people and they won't believe you. They will not believe you that it is that addictive, but we know in fact that it is.

It goes back to the issue of the pharmacists. They have controlled substances, codeine, morphine, and these come under very stringent federal regulation. They would have us believe, "We can keep that locked up in the dispensary, but I can display nicotine products, tobacco products," where everybody's going to have to see it because it's right behind the cash register. I have difficulty with that.

At this point, I'd like to introduce Marjorie so Marjorie can tell you what she's here about.

**Ms Marjorie Shaw:** I'm here because I am a smoker, a very confirmed smoker. As far as I'm concerned, that means I'm addicted to nicotine. I have certainly tried to stop smoking. I've used all the crutches out there that are available. I tried the Nicorette gum but it didn't work, probably because I don't like chewing gum. I tried a couple of the behaviour change programs that are available. One consisted of collecting all your old cigarette butts and saving them for an eternity. That's pretty disgusting even for a smoker, I can tell you, so that went out the window. The other one I tried, the behavioural changes were just so unnatural: One day you were eating dinner at 5 o'clock in the afternoon and another day you were eating it at 10 o'clock at night. It just turned your whole life upside down and was totally impossible.

The last time that I tried to quit was about a year ago. The patches were out at that time, and I thought, "Now, this may work." My family doctor agreed to write me a prescription for eight weeks of patches. I spent two solid weeks of about two or two and a half hours every evening planning my own personal behaviour changes so I would get out of this trap I was caught in, but behaviour changes that I felt were tailored to my life that I could live with and still carry on. I did the best on that

program that I did on any I had tried, till I got down to about five cigarettes a day. I couldn't get it any lower. Those are five essential cigarettes; at least to me they are, at the moment.

I should know what smoking is all about and why I should stop smoking. If it all happened up here in your head, there'd be no problem. I'm a nurse. I work at the cancer clinic. I work primarily with palliative patients, patients who are dying with their disease. Daily I'm helping these patients and their families cope with the disease and with the dying process. Many, many of these patients were heavy smokers. I know that statistically cigarette smoking is a high-risk contributing factor to cancer. If it were just logic and knowledge and so-called intelligence, I should be able to quit.

So why don't I stop smoking? There are many reasons, and I'm very good at rationalizing; that's a very good defence mechanism which works well for me. Some are:

I started smoking when I was 16, so the damage is already done, it's too late. I don't have any major lung problems: I don't cough, I don't wheeze, I don't have frequent infections or anything like that, no signs of problems with it. I get lots of exercise outdoors. I live in this clear, rarefied air of Sudbury—at least I do now; I didn't always. I walk a lot. I have a dog. We get lots of exercise together. I do cross-country skiing in the wintertime, gardening in the summertime.

I also can say to myself, "If I weren't smoking I could be doing other things, probably worse, to deal with the stresses in my life, so maybe smoking isn't so bad after all." And although many of the patients have smoked, regularly we see patients who have never smoked and are still dying with their cancer.

There are lots of contaminants I'm exposed to that I have absolutely no control over. I lived in the Golden Horseshoe for umpteen years. Now it's amazing when I drive down. I can see this pall of smoke and fog over it as I'm going down Highway 400. I think, "I used to live in that stuff."

**Mr Wiseman:** You just want to turn around, right?

**Ms Shaw:** Well, I don't do it any more often than I have to.

And I tell myself I might as well do something I enjoy, that I get some satisfaction from, so I smoke. But really the bottom line is that I don't quit because I can't, because I'm addicted to it, and nothing so far has come along in my life to say, "You must stop smoking."

I do console myself also with my accomplishments, and I have made a few; this all hasn't been totally in vain. I used to smoke Buckingham cigarettes.

**Ms Murdock:** Pretty strong.

**Ms Shaw:** I don't any more; they'd probably kill me now, actually. I'm down to the extra-light, so I've certainly reduced the nicotine by a fair amount. On bad days I do smoke 15 to 20 cigarettes, if I'm having a really stressful day or for some reason it's a heavy smoking day, but on good days, and I have many of those too, I smoke five, so it's a fluctuating number. But until something happens in my life that scares the hell out of me or really convinces me, I will never stop smoking.

I'll smoke for the rest of my life. That's all I have to say.

**Ms McChesney:** On that note, I thank you all for allowing us to present to you.

1520

**Mr McGuinity:** I just want to comment on your sting operation. I thought it was very resourceful on your part. One of the things I recognize since being elected in 1990 is the severe limitations of what government can do. I was very impressed by a gentleman who was here earlier with his daughter, telling what he's doing as a father and as a responsible member of a community.

This is just an idea, and you'd want to check with a lawyer first on this. The Ottawa Citizen once a year goes to a number of auto garages. There's a particular problem associated with a car and they know what it is. They take it to eight shops and get a price for the work that needs to be done, and then they print it. They tell people who the less-than-honest workers are and who the more honest ones are.

You may want to conduct your sting on a biannual basis, without telling people, of course, and you just keep everybody on their toes. That's a way you can assist and maintain the profile at a press conference, and all the retailers are out there on their toes.

**Ms McChesney:** That's not a bad idea.

**Mrs Cunningham:** I just wondered what you think about these fines. I found it appalling when you pointed out to us that there are fines now but nobody is enforcing the existing legislation. I suppose that's why some individuals have come before the committee and said: "They should be licensed. They'll lose their licence and can never sell them again." The fines are going up, but the enforcement might be the difficulty. There certainly would be less to enforce, wouldn't there, if you just took their licence away?

Second, others have said, and you might have said, "Put it in with the beer and the wine in the LCBO."

**Ms McChesney:** That's certainly one option: Grab a corner of the liquor store and put the cigarettes in. Why not?

**Mrs Cunningham:** Maybe that would be a deterrent for you. If you kept running into the liquor store every day, people wouldn't think you did such a good job. I don't mean that, you know.

It's going to take tough stuff. I think your point was, don't let them get started.

**Ms Shaw:** That's right. I started when I was 16. The answer is "Don't start," not "Stop." The answer is just not to start.

**Mr Wiseman:** I believe you are referring to what is called an emotionally significant event that will be necessary.

**Ms Shaw:** Am I? Okay.

**Mr Wiseman:** This hasn't been raised before, and I'll probably get shot by the ministry for even raising it. What if something was built into the legislation that would allow for a civil suit to be lodged against the seller of cigarettes if he's caught selling them in contravention of the law, that if somebody sold my daughter cigarettes



and she was under the age, you as a group or I as a parent could take them to court and sue them for doing it?

**Ms McChesney:** I like the idea. The only difficulty with that is the cost involved. That is always a deterrent for people. When I was looking at what the feds have been doing, I swear if I had a young child—mine are all grown up now—I would seriously contemplate a class action against the government for recklessly endangering the health of my child.

**Mr Wiseman:** That's along the lines of what I'm thinking about. I know in the Environmental Bill of Rights we put into it that any two people can challenge the ministry, that if there's damage to the environment, there's an immediate move where you can go to sue and launch a civil action. This just occurred to me while you were making your presentation. If we don't have the resources in terms of being able to enforce by having police and everybody doing it, maybe we need to empower citizens to be able to do it themselves.

**Ms McChesney:** Anything we can do that will help in the area of enforcement, the sting operations, allowing people to launch suits, may well be a part of it.

**The Vice-Chair:** Thank you very much.

1530

DAVID WEBSTER

**Dr David Webster:** My name is Dr David Webster. I'm a nuclear medicine physician in the city. I did general practice for about seven or eight years before I came here, so I have had some personal experience in dealing with the tobacco issue.

I'd like to thank the committee, first of all, for allowing me to come here and do a presentation on behalf of Bill 119. This issue is very dear to my heart. I'm actually one of the people in the front line who has to deal with the casualties from this tobacco industry.

The most clear message I want to give here is that you've got our full support in introducing this bill, and I would encourage you not only to pass it but to strengthen it.

At the same time, I've got to be honest with you, I have a lot of anger and resentment inside me. You people have been aware of the very same information that we have over the past couple of decades. To say we could offer this up as an example of where politicians have reacted to a major public health concern—it's not a very ideal model, particularly given the announcement yesterday from Mr Chrétien. He shamelessly sold the Liberals to the tobacco industry. He set philosophy back to the pre-Socratic level for the criminals; that is, might is clearly right currently in this country.

Our own local Diane Marleau I would like to call our new minister of disease. Where were her concerns? Not particularly with the health issues. She was concerned that "one of the members of the Canadian family," ie Quebec, was losing out on some profits. That was her major concern.

Mr Rae doesn't know me, but we've had some definite differences on philosophy. I'm a physician, after all. But I have the most profound respect for Mr Rae's stance on

this issue. As Ontarians we can be very proud, if we cannot offer this up as a model, of him taking a very honourable stand for us.

To get back to the issue of Bill 119, this is a public health issue. The information is absolutely overwhelming in favour of not only passing this bill, but one could effectively argue to increase it. What I have trouble with is reconciling that with, for example, the NDP's response to, say, the asbestos industry. When the NDP was in opposition a number of years ago, you may recall that, over about a dozen or so worker deaths, these people were prepared to go to the wall on that. They shut the Legislature of Ontario down for probably 10 days. They played a pivotal role in shutting down the asbestos industry and removing the stuff from our offices and our public places. I'm having a little trouble reconciling that with this issue.

We as the public, I as the public, need an explanation about why, now that the NDP is in power, in spite of all the promises that were given to us—the fact that this bill was even introduced is a bit of a miracle. If it hadn't been for rather profound and aggressive lobbying by the anti-tobacco groups and public humiliation of the government, we wouldn't be here talking today. We all know that in September the caucus officially recommended that this bill not be introduced, that it somehow wasn't important enough for their consideration.

Not important enough for their consideration? By their own figures, there is one death every 40 minutes. We know we've got several thousand kids per month getting addicted to this. This comes from a government, by the way, as it restructures health care, that keeps harping the line, "We're concerned about preventive health care." This is the single most important preventable health care issue in the province. To be kind, clearly people have been dragging their feet a bit. I, as just a plain, ordinary person on the street, would like to be able to reconcile that in my own mind.

Quite clearly, the issues of rights and freedom of choice do not hold water on this one. I don't have a choice to wear my seatbelt or put saccharine in my coffee or asbestos wallpaper on my room. Is there a person in this room who doesn't believe, a person in Canada who doesn't acknowledge, that the issue here is solely profit?

Don't get me wrong. If you knew me personally you'd realize that I'm all for free enterprise, but—call me crazy—I have a little problem with an industry and a tax-revenue base that is somehow based on the fact that it requires 2,000 or 3,000 kids per month to come into this market. Unfortunately, it results in one death every 40 minutes, not to mention the secondhand smoke effects, the disability, the chronic care hospitals, the effects on unborn foetuses and so on. I have a problem with that. I'm having trouble understanding why we're not seeing a more aggressive response if people are really, truly concerned about health issues.

I've heard these concerns from business, and they really are real. One of the concerns I heard raised was the paperwork because this now would become a regulated product. Can anybody possibly offer me an explanation? If there was ever an example of a product that required

regulation about who could sell this stuff and who could buy it, surely this has got to be the granddaddy example of them all, but we're concerned about the paperwork.

I'll tell you about some real paperwork. As a physician, I have actually sat with patients who were dying from smoking-related illnesses, and after they die and the body is cooling, I have to go fill out some paperwork: their death certificate. There I sit pondering in my mind that here is this person who's part of this sacrifice on the altar in the name of profits. Their life is summed up to a cigarette.

The bottom-line argument to date has been that this at least has been a source of profit and we can put the profits to good use for social programs and so on. I'm hearing things about business wanting compensation. I couldn't agree more. The government has turned a blind eye to this issue for so long that you've created a whole mass of industries and stores for which a large part of their business actually depends on making profits off this stuff. They are really going to be in trouble. I think you owe it to them to come up with some sort of compensation package if what we hope happens: that tobacco usage and income and revenue profits go down.

I'm speaking now directly to politicians who oppose this, who are embarrassed by this, who wish this bill had never got here or would like to dilute it. I wish they could tell me how it is that the numbers, for example 13,000 deaths per year in the province, aren't enough to impress them. I would like to know from you people today just what kind of death figures, what kind of addiction figures would it take to move you to actually switch your arguments over clearly to the health side? Yes, work on compensating business, but nevertheless put your major efforts towards strengthening this bill and taking some definitive action here.

Moving to pharmacy, in the health profession, as you might appreciate, this is surely one of the most embarrassing issues for public health professionals that I can possibly think of. I cannot believe that intelligent people are actually willing to hide behind the "legally available product" argument. I would love to have been here when they were thinking about banning thalidomide to see whether these people would have been upset because they were going to remove one of their products.

These statements are totally devoid of any moral or ethical principle, and that's what it comes down to, quite clearly. The public needs to know that the issue of whether sales in pharmacies should be banned, which is so obvious, was actually brought forward by the College of Pharmacy, as I understand. They want this to be produced. It is the professional regulating body of the profession of pharmacy that wants to establish a principle, a code of ethics, which everybody else in the health care profession has to stand by.

Could we have a better example of a conflict of interest, of professional misconduct—as used against physicians all the time—of behaviour that is not in keeping with the honour of a health care profession? Yet we have people who will actually say: "We want to be able to sell out the front of our stores the leading cause of death in this country and we want to sell the products

to treat it from the back of the store. At the same time, we want to be considered respected members of the health care community."

We keep hearing about education from the pharmacists. If you want to send a message loud and clear about just how deeply in the back pocket of the tobacco industry you are, go against the college on this one. The college is asking for the power to do this. Stand up against them and be willing to say, "We don't care. We've got profits at stake here, we've got bottom-line ledger figures at stake here."

What an incredible precedent. In the past, the members of the opposition, for example on asbestos, have been the ones who have been hounding the government to take some action and behave responsibly about the information it had available—I remind you of ethyl carbonate contamination in wine a few years ago in South African wines—demanding responsible behaviour and resignations. Now we see members of the opposition wanting to water down or eliminate a bill that—with the health care issues on this one, the other ones combined don't even get on the same planet of scale of the implications of this. Quite clearly, this is just an embarrassment for the profession.

What I like to do here now, and what I would like you to take away most, is that we keep hearing these numbers bantered around glibly about deaths and about addiction and about the profit motive for all of this thing; this is what justifies this. By their own figures, it's one death every 40 minutes: Each one of those deaths represents a real person with a real name, with family and relatives.

This is a case example. When I was in practice there was a man in his early 50s. He spent his life building up a thriving business in the local community. His family is all grown up, they've got their education, they're bringing the grandkids over to see grandma and grandpa. This man comes in with a spot on his X-ray and a little bit of a cough. The man had inoperable lung cancer and eight months later he was dead. I was a family practitioner in a rural setting actually doing house calls, and I sat and shared some of the grief of that family as that man slowly died. You should have been there when he had the spread of cancer to his brain and was completely delirious and uncontrollable.

The point I want to make is that these are the real faces behind those numbers. These scenarios are being played out as we sit here and speak. This is blood money we're talking about that we're living off here. Am I being melodramatic? I don't think so.

I can give you a more personal example of my own father. My father was a faithful supporter of the profits of the tobacco industry and tax revenues for the government for many years until he developed—sorry, I'm on a roll.

**The Vice-Chair:** I am listening to every word you're saying.

**Dr Webster:** He developed a cancer of his throat which wrapped around his carotid artery, that major artery supplying his brain. You remember in the horror movies, they slit their throat and these people bleed all over the place. He was told, and we as a family were



told, that how we could expect he would die is that the cancer would erode through his carotid artery and he would simply bleed out his blood volume on the floor in front of us. You can imagine the terror of that man and our family sitting there trying to have polite conversation as he's dying, wondering if in the next moment he's going to erode through and simply bleed out in front of us. He didn't. He suffocated to death. It might be argued medically that he'd have been a lot better off to simply bleed out. It would have been a little traumatic for a while, but he would have died much quicker than he did.

The point I want to make is that you can sit around in all of your philosophical discussions and talk about balanced figures and profits and incomes and expenses, as we constantly hear about. This is what it translates to at the street level. That's what we deal with. That's what the families are dealing with. To borrow a term from *The Sports Network*, we've got real life, real drama here; real death, real human suffering.

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I would like to close by saying—I've probably gone over—that we need to send a message to the kids of this province that governments are not impotent, like the federal Liberals, that we can actually take a stand on an issue which—who could argue?—is the most profound and important issue in public health that has confronted us in the last 40 or 50 years. You need to take strong measures to make sure, absolutely, that you keep this stuff out of the hands of kids. Give an unequivocal message to them. I know most of you politicians support that. I'm really aiming this at the people who do not.

We obviously need to make the point that this product is clearly different from any other consumer product we can possibly imagine. If that means putting the stuff in plain packages with strong warnings on it, yes, we may need to, as governments have in the past on issues of public health, infringe slightly on the freedom of expression and so on of various companies and businesses.

I haven't talked about secondhand smoke in the environment, but even the government here introduced workplace environment legislation. If the levels of pollution in an industry got as high as they do in any bingo hall in the city, the NDP government, the unions and so on, would have the power now to shut that place down. But somehow we see this going on every day around us.

We need to remove this poison from the pharmacies and get on with life here. This is an embarrassment.

You have a rare opportunity. I've obviously been carrying on in a bit of a tirade on this whole thing. You can see I have a lot of passion and anger about this, for lots of reasons. But I would like to do anything I could to encourage you. You've got the support of the health care community, that's for sure, to go with this, and I would encourage you to go even farther, particularly in light of what's happened. The Liberals have simply eliminated most of the gains that have been made by the health community of this country in one foul swoop, if that actually passes through.

You have a unique opportunity as politicians to stand

up, like Mr Rae. How many people are going to stand up and rave about Diane Marleau's response on this issue? How many people will stand up and rave about how proud we can be of Mr Rae, that somebody has finally stood up against the juggernaut of the tobacco industry, been willing to accept its wrath and actually go forward on an issue of public health, clearly and finally give a message to society that we can deal with these issues, that we can move on?

I'll end there, and I will be happy to entertain any questions, if I can answer them.

**The Vice-Chair:** We're very short of time for questions, however.

**Mr McGuinty:** Dr Webster, thank you. You certainly didn't allow us time to dose off.

In fairness, we all have to assume some responsibility for this problem. I don't blame the tobacco industry. I blame us. We allow them to exist.

**Dr Webster:** We agree on that.

**Mr McGuinty:** But I want to focus on the medical profession for a minute. My perception as a layperson not overly acquainted with medical problems is that the greatest problem facing us in terms of medicine is AIDS.

**Dr Webster:** No, not at all.

**Mr McGuinty:** But that's the impression I get from medical people or what I read in the newspaper.

**Dr Webster:** Well, they're very selective in that. It's certainly far more dramatic, but if you look at the number of deaths per year of AIDS victims, they don't even get on the same charts. AIDS is a major issue because it also is preventable.

**Mr McGuinty:** I agree with you.

**Dr Webster:** Here's a figure: 45 times more deaths from tobacco than AIDS. You've probably heard that.

**Mr McGuinty:** We've heard that several times, and I agree with you completely.

**Dr Webster:** If we were duping you into believing those figures, you should have been there to point out to us that in fact we were wrong, because you had those numbers.

**Mr McGuinty:** Why doesn't the medical profession get together, whether it's the World Health Organization, the medical officers of health for Ontario, and declare, "This is an epidemic"?

**Dr Webster:** Lots of individuals have said that. In fact, in the Ottawa-Carleton area you may be aware that there's a group of physicians who make statements, who've tried to say that smokers themselves have responsibility on this issue. They want to be able to take smokers off the coronary bypass list, for example. Physicians have made statements as individuals.

**Mr McGuinty:** I support those doctors entirely, but my perception is that they really constitute—not a renegade group, that's not the right word, but they just don't seem to fall within mainstream medicine.

**Dr Webster:** The problem at the moment is that physicians—and I'm not trying to make apologies for them. I am doing my bit up here on their behalf, and to

be quite honest, I'm a little ashamed that we're not seeing more response from them myself. But at the moment, as you might appreciate, there are a lot more issues on their plate. As these issues have been finally, for once, brought to the attention of the government and the media, there are a lot of other things doctors have on their mind.

I'm telling you, we're a little busy up here to try, for example in Sudbury, to have the time and make the effort it requires. I took the day off work. I'm the only nuclear medicine physician between the Sault and North Bay, and in fact the only qualified one up to Thunder Bay here. I took the day to sit and think about this and worry, and as you might imagine, I'm not used to speaking.

**Mr McGuinty:** Don't practise. You're already good.

**The Vice-Chair:** Thank you for a very stirring presentation. It's appreciated.

The parliamentary assistant would like to make a clarification.

**Mr O'Connor:** Mr McGuinty asked why the medical officers of health don't say something. In fact, the chief medical officer of health on page 2 of his report, which we all have, says: "Tobacco-related diseases are this province's number one public health problem. The cost in human lives and quality of life and health care dollars is colossal. The circumstances call for nothing less than thorough and relentless action by all Ontarians." The chief medical officer of health, and I think we'll probably hear from another medical officer of health today, has stated quite clearly that it is the major problem we face in the province.

**Dr Webster:** I would like to ask the politicians who have spoken against the measures in this bill, if we turn the clocks back just a little—

**Mrs Cunningham:** Nobody's speaking against it.

**Dr Webster:** Nobody here? Well, what about the pharmacies? Who's speaking on it?

**The Vice-Chair:** There are questions about it.

**Dr Webster:** We talk about educating the kids of this province. What do you think the message is to the kids of this province? We're talking about education here.

**Mr Jim Wilson:** I'll tell you what I think. We've gone to great lengths to ask kids. They think poison products are kept in pharmacies, and if you ask them, they say that cigarettes, if you're really worried about it, should go behind the counter. So if you try and apply some logic to this, it should go out of all retailers and into where all the other poisons are put in our society, behind the counter.

**Dr Webster:** But you argued against that. I would have to agree with that.

**Mr Jim Wilson:** No, I wouldn't argue against that. That's what I'm arguing.

**Dr Webster:** You're arguing that it should be taken out of the retailers—

**Mrs Cunningham:** We're saying they should be licensed.

**Mr Jim Wilson:** You can't pick on one retailer. It makes no logical sense to pick on one retailer.

**The Vice-Chair:** We have degenerated into a general discussion on this matter.

**Mr Jim Wilson:** When I was a kid, pharmacies were a place where poisons were kept. If you ask kids that now, they agree with that.

**The Vice-Chair:** If I, as Chair, had the opportunity, I would have asked you, "But why aren't you asking for a ban on tobacco for ever?" However, I'm the Chair, and I can't get into that.

Can somebody phone the airport and tell them the plane has to be held an extra hour? We can't make it.

*Interjections.*

**The Vice-Chair:** I'd love to stay in Sudbury tonight.  
1550

CATHY DASHPER

**Ms Cathy Dashper:** My name is Cathy Dashper, the pharmacy manager at the regional cancer centre here in Sudbury.

I strongly support Bill 119 and its aim to decrease smoking among young people as well as banning tobacco sales in pharmacies. My support stems from being a health care professional at the cancer centre as well as being a pharmacist concerned with the integrity of the profession of pharmacy.

At the cancer centre we see hundreds of patients every year diagnosed with cancer related to tobacco use. We know that tobacco use kills. It follows that cutting tobacco sales means savings lives. It's a start for tobacco sales to be banned in health care facilities. Ideally, this will lead to the restricted sale of tobacco by a controlled vendor, like the Liquor Control Board of Ontario. This ban should send a message to our young people that a package of cigarettes is a hazardous product, not to be considered another casual purchase like a candy bar in a pharmacy.

Unfortunately, our federal government has decided to decrease the price of cigarettes and thus make them more accessible to our young people. This is one more reason to support Bill 119 and to support the Ontario government's resistance to reduce the tax.

Speaking as a pharmacist, I have been encouraged by the Ontario College of Pharmacists' initiative in trying to remove tobacco from drugstores. It does not make sense for a health care profession to be selling the country's leading cause of preventable death. In 1989 OCP adopted a policy of disapproval of tobacco sales in pharmacies and asked for voluntary removal of tobacco from pharmacies. As this voluntary approach was discredited by Shoppers Drug Mart and other chains, the Ontario College of Pharmacists petitioned the government to legislate the separation of tobacco sales from the practise of pharmacy.

With the introduction of Bill 119, the Minister of Health is complying with the request of our college. When pharmacies such as Shoppers Drug Mart oppose our college's request for legislation it really undermines pharmacy as a self-regulating profession.

In summary, Bill 119 is a definite step in the right direction. It sends a clear message to the general public



and particularly to young people. This message is that tobacco products are hazardous and not to be used casually. It also sends the message that pharmacy is a health care profession and the sale of tobacco is incompatible with a pharmacist's code of ethics.

**Mr Wiseman:** It's starting to bother me in the back of my mind, and I'd like to ask the researcher if somebody could comment on what we would have to do to this bill to give parents and to give groups the right to sue retailers or pharmacies that have sold cigarettes to minors, thus addicting them to this drug. If somebody could help me with that later on, at some other time, I'd appreciate that.

**The Vice-Chair:** Would you like to record it? We'll have it reported at a later date.

**Mrs Cunningham:** It's sad that we've got a law right now and it's not being enforced. I'm on your side.

Do you think if the liquor control board were in charge of the sale of cigarettes we wouldn't have to listen to this argument any more about who sells them? It gets to be a real problem and I think we have to take it beyond what the legislation says right now.

**Ms Dashper:** If it was sold in the liquor control board, it would decrease the use. The young people would know for sure that it was a hazardous product and not, as I said, a candy bar they can just go into a drug-store and pick up whenever they want, especially the kiddie packs they're selling. We think it's atrocious.

**Mrs Cunningham:** By the way, some of the examples that have been used today are not in legislation or in regulations, but we don't know what the regulations look like. It won't be difficult to put the list together; in fact, Mr Gardner already has done that as the researcher to the committee to let us know what positions are being taken by the public. They're under certain headings, and we'll be looking at them and offering amendments or recommendations to the government for their inclusion as part of the regulations.

I think you have come on rather strong, and I support you in this regard. It was in London just on Monday that we heard from a medical officer of health for the first time who said there should be some responsibility on the young person who of course is smoking underage. Of course some of the school representatives have told us what a difficult time they're going to have, and they've tried themselves over the years and need this kind of legislation to ban smoking of cigarettes from schools. We're going to strengthen it, hopefully—the parliamentary assistant said we will—to include school property. Now we've got these young people who will continue to smoke because they will be able still to get these cigarettes, in my view, if we don't strengthen the legislation. Would you fine them? What would you do as a penalty? If we're teaching responsibility in today's society, which I don't think we do enough of, what would you do?

**Ms Dashper:** That's a difficult question. I suppose if they're going against the law, they should be fined. The trouble is that these kids have barely enough money to buy this package of cigarettes. How are they going to pay the fine?

**Mrs Cunningham:** It's true. A lot of people have come before and said community service, so that's another alternative we're thinking about, that they would be required to do some hours of community service, which of course is a sanction the courts use sometimes for young people.

**Ms Murdock:** In the cancer care treatment centre.

**Ms Dashper:** Yes, to see all our patients.

**Mrs Cunningham:** Would you think about it? We would love to hear from you subsequently, because it is a question that has come up as a result of presentations. It's fine to tell legislators and governments to do things, but we like to get the support too, and when I ask a question like that, there are a lot of people who think and say, "Ah, not my kid" or "not the kid down the street" or something. I think it's time we take those kinds of stands.

**Ms Dashper:** They really have to be warned of the hazards, though. So many kids just think it's not going to happen to them, that cancer of the lung is something that happens to somebody else.

**Mrs Cunningham:** Public health officials in schools and teachers are telling us that they've been doing this kind of education for 30 years.

**Ms Dashper:** But the rate of smoking in women is increasing at an alarming rate.

**Mrs Cunningham:** It was amazing, wasn't it?

**Mr O'Connor:** Thank you for your presentation and for the strong points and the way you delivered them. We're trying to focus on the young people, and that's really where I want to try to focus a lot of my attention and energy, and I try to get into as many schools within my riding as I can to talk to young people about this. I just wondered, are schools brought into the regional cancer centre you're part of, or are there problems of confidentiality? Is that used as a tool to drive home the message to kids that it kills?

**Ms Dashper:** We've had our paediatric oncology nurse go into schools to talk about cancer. I don't think we've had school children into the centre. We've had them paint pictures for us about sun awareness week, that sort of thing, and different hazards within the community, but I don't think we've ever had children come in and I don't know that it would be appropriate to see the radiation. No, I don't think it would be appropriate.

**Mr O'Connor:** That's why I wondered, the confidentiality kind of problem.

**Mrs Cunningham:** Just for your information, at the risk of dating myself, in the 1950s in Toronto we went to Toronto General Hospital and saw pickled lungs of smokers. I'm sure you wouldn't call them that, but that's what we called them, and it wasn't offensive and it just taught you not to smoke.

**The Vice-Chair:** Would it ever.

**Ms Dashper:** I think there are many exhibits to that effect.

**Mr Wiseman:** I remember as a three-year-old going to that office.

**The Vice-Chair:** Thank you very much for your presentation. It aroused a great deal of interest.

MICHAEL BORKOVICH  
TERRY BRISTOW  
RICCO BERARDI

**Mr Michael Borkovich:** Good afternoon, Mr Chairman, members of the committee. Thank you for the opportunity to be here today. My name is Michael Borkovich, and I'm the pharmacist-owner of the Shoppers Drug Mart in the Sudbury Super Mall on Lasalle Boulevard. With me today is Terry Bristow, the pharmacist-owner of the Shoppers Drug Mart on Long Lake Road in the Four Corners Plaza. Also with me is Enrico Berardi, a store accountant and part owner of the Nickel Centre Pharmacy in Garson. Nickel Centre Pharmacy happens to be an independent pharmacy.

First of all, let me say that we strongly support the intentions of Bill 119, to work towards making Ontario a smoke-free society. The controls you propose to curtail the sale of tobacco to minors are commendable. Anything that discourages people, especially young people, from smoking will help you achieve this goal.

However, we cannot support the pharmacy ban included in Bill 119, and we want to explain to you why we believe you should remove subsection 4(2) from the bill. There are three key messages we want to leave with you:

(1) The sale of tobacco should be the voluntary decision of the pharmacy owner, depending on their economic format, and not something that is determined by the government.

(2) Pharmacists are very diligent in ensuring that we do not sell tobacco to minors. If you take it out of pharmacies, you will essentially be making it easier for young people to buy tobacco from retailers who are less concerned.

(3) There will be no health care benefits from this legislation. Nothing will be achieved and no one will stop smoking as a result of the pharmacy ban.

I presently employ 40 people, 23 full-time and 17 part-time. Tobacco constitutes about 10% of my sales, so if I have to remove tobacco I will likely have to reduce my wage hours by an equivalent amount, which means I will have to cut back my staff by about four people. This will result in job losses. That does not take into account the impact this will have on additional sales that are generated when a tobacco purchaser comes into my store.

There is no other product I can add that will generate 10% of sales. Presently I sell tobacco, cosmetics, confectionery, over-the-counter goods, health and beauty aids. I sell these products because it is an economic decision. I am not endorsing the purchase of any of these products. I sell these products because my customers want to buy these products in my store. If other pharmacists decide not to sell tobacco, or any other product, that is certainly their right and their privilege to do so. But it should not be the decision of the government to tell me as a retailer what I can and what I cannot sell.

The profession of pharmacy is clearly split on this issue. Therefore, it should be left up to the individual whether to sell the tobacco. When I am in the dispensary, I am a pharmacist. I counsel patients, check drug profiles,

call physicians and use my professional judgement in every prescription I fill. But when I leave the dispensary I am a retailer in a very competitive environment. I have to make sure I provide even better prices, better service, better selection to be a successful retailer. I am both a retailer and a pharmacist.

#### 1600

According to a new study by Coopers and Lybrand, over 2,700 full-time and part-time jobs in the province will be lost and from 120 to 140 pharmacies will close if they prohibit the sale of tobacco. In northern Ontario, this translates to 196 jobs that will be lost and 10 community pharmacies that will be closed. There definitely will be whole communities that will no longer have pharmacy service, especially in the north, as a result of this legislation.

Before I pass this on to my colleagues, I have to say that I cannot understand the logic that was used by the college and now by the Ministry of Health. I really cannot see how removing tobacco from pharmacies will have any impact on the amount that is smoked. There will be lots of retailers who will fill the void, both legal and illegal. In my mall alone there is an Inclination smoke shop, a K mart and an independent grocer, all of which sell tobacco. I do not believe that any smokers will stop smoking because they can't buy tobacco from my store, and in the end, the only impact will be on my staff, and it won't be a positive impact.

**Mr Terry Bristow:** Good afternoon, members of the committee. You'll have to excuse me; I'm just getting over the flu.

You have heard a number of presenters claim that pharmacies are the most responsible vendors of tobacco, and there have even been proposals that pharmacies should be the only place where you can buy tobacco.

Let me tell you about how I ensure that my employees never sell tobacco to minors. When I hire new employees they undergo a fairly lengthy orientation process. They must view a video about the sale of tobacco to minors which was produced by the Retail Council of Canada. Every new employee spends several hours working directly with a supervisor. The supervisor would demonstrate to the new employee how to ask for identification from tobacco purchasers if they suspect they are underage. Often this is quite forbidding for a new employee, but we have made it an accepted practice in our store and that makes it a lot easier for the novice employee.

We also have decals on our cash registers showing that tobacco will not be sold to anybody under the age of 18 as a constant reminder to our staff. Every new employee also reads and signs a declaration that they will never knowingly sell tobacco to minors and that it is grounds for dismissal if they do. Nobody is saying there will never be mistakes, but I can assure you that no other type of retailer is going to the same lengths as we are to curtail this activity.

The stated intent of this legislation is, and I quote from the Minister of Health, "Effective, far-reaching legislation that discourages people, and especially young people, from becoming addicted to a deadly habit." I can tell you



that pharmacy is your friend in all this. We are the most responsible vendors of tobacco. We can assure you that all necessary steps are taken in a pharmacy environment so minors cannot buy tobacco. Without pharmacy, as Michael pointed out, the sales will very quickly shift to another type of retailer, and they may not be as diligent about the sale of tobacco to minors. How does a corner store operator train their staff? Do they use videos and sign declarations? Often there is only one sales clerk in the store at any given time, so how can they possibly ensure that their employees are never knowingly selling tobacco to minors? The same applies to gas bars. They rarely have more than one sales clerk at a time.

In my store I employ more than 50 people, and my pharmacy's open until 10 pm every day to offer extended-hour pharmacy service. Tobacco is only one of many categories that I sell in my store. In my case, tobacco makes up 10% of my sales. There is no doubt about it; I will have to reduce my wage expenses by a proportionate amount. I will have two choices: Either I cut staff or I cut my hours of operation, which means that my customers will not have a pharmacy service late at night. I urge you to reconsider this legislation so that I will not have to take either of these dramatic steps.

**Mr Ricco Berardi:** My name is Ricco. I and my brother co-own Nickel Centre Pharmacy, which is just on the way to the airport where you're going to catch your late plane.

I wish to thank you, first of all, for allowing us to make a presentation to hear what I have to say. What I have to say is unique to me. It's not unique to Shoppers or Pharma Plus or any other group; it's us.

As a family-owned business, I ask you, when you go back to Toronto or at the end of these presentations, to seriously consider exactly what's going to happen. The objectives of Bill 119, as I understand them, are first of all to decrease the amount of smoking, to decrease the number of smokers, and especially and above all, to reduce the chances that young people will start smoking. We are in complete agreement with that, but I'm not sure how the ban on the sale of tobacco in pharmacies is going to help achieve that. Pharmacies do not cause people to smoke, and that should be clear. We are also probably one of the most diligent in ensuring that those under 18 do not purchase tobacco.

In our pharmacy, we have cut back on the visibility of tobacco to the point where it occupies a small section behind the counter and is no more than three feet high. What was once cigarettes has now been replaced by Duracell batteries and Eveready batteries. We have noticed that our tobacco sales got slashed to just over half. We also noticed that sales of lottery tickets, for example, dropped. We also noticed that sales of some confectionery items dropped.

If you take away certain revenues from us, as a business person I have to tell you we're going to have to re-examine the expense side of the equation. The biggest expense is wages. I don't know what's going to happen. You might argue: "Well, replace them with something else." I don't think we're that atypical. Our lease, for example, restricts us to what we can sell. We can only

devote a certain portion of our store to foodstuffs because there's a major food store and it has an exclusive. We can't rent or sell videos because there's a video store in the mall. You say, "Be creative." We've looked at all those options, and because of our circumstances they're not available. If you drop tobacco from ours, we don't have a product to replace it. That's a fact of life.

I seriously question the fairness of the law that prohibits us from selling a legal product when in our mall there are three other places where you can buy tobacco, the furthest being about 130 feet away. If you don't like the price you can go to the arenas and place your order for cigarettes and liquor. I guess I'm just confused. I'm not quite sure myself sometimes.

Our retail format is very different from the format of a medical centre pharmacy. We don't have 25 general physicians above us sending prescriptions our way, or have an elevator that happens to open to the door of a pharmacy. We're not a big community, and the front-shop items complement or allow the dispensary; the dispensary allows the front shop. They go hand in hand almost, but they do allow each other to exist.

Wal-Mart, for example, is coming to our town, and 80% of the Wal-Mart stores have pharmacies. We don't want a situation where some of these large retailers can simply fence off a new area or put a wall and have their own little door and circumvent both the spirit and the intent of the law, because then the field is not level.

It's just fairness. I just want you to understand where we're coming from. These others are going to have a competitive advantage over us, and it will impact upon us. This is the fourth year of a major recession, and every little bit helps. I don't know when it's going to turn around.

I want to also refer to a letter from a pharmacist who did voluntarily stop selling tobacco approximately four years ago. This letter was addressed to Mr Charles Beer.

**The Vice-Chair:** Mr Charles Beer is the Chair of the committee, above is absent today, so I have the privilege of filling in.

**Mr Berardi:** It was written by Luke Michaud. He and his dad own Health Care Pharmacy. This appeared in the Sudbury Star on February 3. The last paragraph reads: "Even though I am 100% in favour of Bill 119, I do believe the timing could not be at a worse time. Pharmacies have had to survive the recession on top of government cutbacks. I'm certain that some pharmacies will have to close if this bill becomes law." This is from a pharmacist who has voluntarily cut out tobacco. We've cut back on tobacco and we've noticed that there have been other repercussions.

In terms of the goals, yes, smoking is bad. I'm going to pass it back to Terry. I just wanted you to hear my side.

**1610**

**Mr Borkovich:** In preparing for this presentation, I took a look at the list of presenters. There were 21 presenters listed on the agenda. Of these, 13 were from health care groups and social service agencies. I could guess quite easily the position these groups would take on

the pharmacy ban. I'm sure they all wholeheartedly support the pharmacy ban.

With all due respect, these individuals who represent health care professionals are not retailers, nor do they understand the realities of retail. Unlike pharmacists, who are both retailers and professionals, they can easily embrace the symbolism of a pharmacy ban because it would have absolutely no consequences to them. They do not have to employ cashiers, stock clerks, receivers, merchandisers. They do not have to worry about the competitor who's next door.

As legislators, you must weigh benefits of a particular policy against the costs. If you do so in this case, you will clearly see that there will be nothing gained by the pharmacy ban but that the costs are substantial. Thank you very much for your attention.

**Mr Jim Wilson:** It's clear that a lot of health groups and physicians don't agree with your position opposing the ban on tobacco products. As Health critic for the Ontario PC Party for three years, I've watched the government's treatment of pharmacists. I don't think they like pharmacists very much. The government has hinged this section of the legislation on two things.

They have told us time and time again, "You have to decide whether you're a retailer or a pharmacist," and time and time again the pharmacists have said, "We're both." They've hinged it also on the college's position, its June 1991 request to the government indicating that it wanted a ban on tobacco products and indicating that you are a health care facility.

That's very interesting, because I sat on this committee on November 29 when that same college came forward and said: "When it comes to the issue of sexual abuse, for God's sake don't consider us a health facility from one end of the store to the other. We want to know from this committee and from you legislators when the patient-pharmacist relationship begins, and we don't think it begins at the front cashier where the cigarettes and chocolate bars are sold; it only begins when that customer talks to the pharmacist, becomes a patient under that act."

It was clear to me at that time that your same college was trying to tell me that it recognizes you're both a retailer and a pharmacist and wanted a clear definition of when that pharmacist-patient relationship began. They didn't want to be responsible for some clerk at the retail end of the store who might make a joke of an inappropriate sexual nature; they didn't want to be responsible for those actions.

Call me stupid, but at least call me consistent. I've always considered them both a pharmacist and a retailer. I got mixed messages from your own college, and I don't appreciate being put in this position. I've told them that.

Second, when the government negotiates with your profession for your ODB fee, the BAP plus 10%, it tells you, "We give you a monopoly on drugs at the back of the store; therefore, we expect you to make money at the retail end of your store and your retail end should subsidize your back end." Particularly with the expenditure control plan and the social contract, this government is talking out of both sides of its mouth when it comes to

this legislation, saying, "You have to decide whether you're a health facility or a retailer," because in its own negotiations it tells you you're both and it counts on you being both. Now it's saying, "As a retailer, we want to single you out for health reasons and we've got the whole health community behind us."

I call it cheap politics. It's cheap politics because the tough decision is to move it out of retail totally and move it into the LCBO or Brewers Retail. They're not going to do that because all hell would break out with every Becker store and Mac's milk and everything in this province, so they've picked on you.

I'm being consistent. I'll go to my grave being consistent on this issue, and my party's been consistent. When people accuse us of being friends of Imasco and that, my immediate response is, thank God Shoppers Drug Mart has come around to the business principles the Ontario PC Party has always stood for. If we happen to be allies on this particular issue, fine, but it's not because of any special relationship with Imasco or Shoppers Drug Mart or anything else. In fact, I would ask where the hell all those companies have been over the last decade while my party's been—

**Interjection:** Floundering.

**Mr Jim Wilson:** —rounding up debts and trying to get back into first place. Let's clear the air on this. Some of us have some principles and don't speak out of both sides of our mouths, behind closed doors in negotiations—

**The Vice-Chair:** The question, please.

**Mr Jim Wilson:** —when it comes to Bill 100, and now you nail them in this thing. I'd like to hear your comments on all of that.

**Mr Borkovich:** Well, that was a 10-minute preamble. I agree pretty wholeheartedly with you. We are pharmacists, we are retailers. There are a lot of different kinds of pharmacies out there. There are medical clinic pharmacies, like Enrico just mentioned, which have four floors of doctors above them and no front store and don't need a front store.

We are not in a medical building; we are not in a medical clinic. We are out in the community and we are a community pharmacy. We have a front store. The front store is very important to our existence. The front store is one of the main reasons we're open until 10 every night and why we're open on Sundays and holidays, which a lot of these medical clinics are not. That's what I wanted to say.

Also, as to the college's decision to present this to the Legislature back in 1991, this was something the council members voted on—there are 10 or 12 council members from the various parts of Ontario—and there wasn't a lot of consultation back then with the grass-roots pharmacists.

If you took a survey, I think it's not overwhelmingly that all pharmacists want tobacco out. Those who are in medical clinics are sitting on the high moral ground. It's easy to say we're professionals. We are. But for those who are in retail and community with front stores that are open extended hours, open on Sundays and holidays, it's



very important to us. By taking it out of pharmacies, I don't think it's going to decrease consumption. I think the downside is much more catastrophic than the upside of taking it out. We're looking at more job losses across Ontario, and I don't think there's any upside. I don't think anybody's going to quit because of taking it out of pharmacies.

**The Vice-Chair:** Thank you for your presentation.

**Mr Wiseman:** I wanted to ask a question, but you gave him all the time. He made a speech.

**The Vice-Chair:** He was the first on the list.

PHYLLIS PALANGIO

**Ms Phyllis Palangio:** I want to thank you all very much for the opportunity to address this committee. I've just come in from North Bay. It was rather a harrowing trip, so if I'm a little out of breath, that's why.

I'm going to represent five people here today; I'm wearing five different hats. I'm going to be as brief as I can introducing them all.

My name is Phyllis Palangio. The first person I am representing is the ex-consumer of the product we're talking about today. My history of addiction with nicotine falls directly into the parameters of most of the people who have been addicted in this province: Starting age around 17, 17 years' worth of addiction, one to two packages of cigarettes smoked per day, and a very difficult time quitting, five tries. I can still remember sitting downstairs at 2 o'clock in the morning blowing cigarette smoke up the chimney so my husband wouldn't know that my third attempt to quit had failed.

The second hat I am wearing today is that of a mother who has three teenage children. As infants, my children suffered from the usual effects of sidestream smoke including lung infections, back-to-back cases of bronchitis, ruptured eardrums. When we quit smoking at home, the children got well.

The third hat I'm wearing today is that of an RN. I have 25 years in the health care field. During that time I have helped people come to terms with the long-term effects of smoking, and I have witnessed their deaths from the terminal illnesses of cancer, lung disease and heart disease.

1620

For the last two years, I have been the director of the Nipissing detoxification unit for drug and alcohol abuse. That has been a very enlightening experience, even after all those years in the health care field. Our mandate is to allow admission to 16 years of age and older for people who are currently intoxicated, in withdrawal or at risk of relapse from chemical abuse. We are seeing more and more 16- and 17-year-olds coming through our door, and every one of them has a cigarette hanging out of his or her mouth.

If you look at the alcoholics we treat in our unit today, more than 90% of them are also addicted to nicotine. Nicotine is a drug of entry into the drug world. It is also a transfer drug. We have a saying in our unit: "Sugar leads to caffeine." If you have something sweet, you think of a cup of coffee. "Caffeine leads to nicotine." You have a cup of coffee, you want a cigarette. "Nicotine

leads to alcohol and other drugs."

We know from experience as well that the clients we're treating are dying from the effects of tobacco use. They're not dying, the majority of them, from the long-term effects of the alcohol or the other drugs they're using. We also know from experience that the effect of nicotine is the same on the body as if a person is using cocaine or heroin. Now, the effect is not as dramatic, you don't get the sudden upsurges and the sudden downhills, but you do get the same roller-coaster ride. The same pattern of addiction is there, and the issues associated with withdrawal are the same for nicotine as they are for alcohol, the same as they are for cocaine, the same as they are for heroin.

Nicotine is one of the most addictive drugs in the world, and if you ask someone who is in our unit for another addiction, what they would like to get off most, they will list nicotine. And they can't; they're still smoking.

Back in January and February 1992, we ran a residential smoking cessation project at the Nipissing centre. This project was a pilot project. We were only able to admit 49 clients. We did not advertise that we were having a smoking cessation program. We called the newspaper and told one reporter what we were doing. The story went local within a day, provincial within two days and national within three. Within three weeks we had 300 people applying for admission to that program and we had to turn down the majority of them.

Some of them were pregnant. We had calls from obstetricians begging us to take their clients. We had some clients who were being threatened with portable oxygen therapy if they did not get off the nicotine right away. We had people going for major surgery within a week.

We took the most serious cases. The success rate for that type of detoxification was over 98%, but because the program could not continue, they relapsed. There was no support group for them to go back to. If the program had continued, it may have been successful.

The average number of attempts to quit before they came to us was five. These people were seriously addicted and seriously in need of help. But one thing that was very evident from that trial we did is that the issue is not to get people off cigarettes. That's not where it's at. The issue is to prevent them from being on cigarettes in the first place.

The last hat I'm wearing today is that of the chairperson of the North Bay and District Council on Smoking and Health. I think everybody on that committee must be from Missouri, because we read all the statistics that were available provincially for smoking and we wanted to prove to ourselves that the North Bay area fell into the parameters that were being outlined for the province. So we got some money together and we conducted a major survey, and I think you may have an executive summary there.

This is the project we did. We surveyed 500 students in our community in grades 7 and 9. To our astonishment, we found that yes, we did fall into the provincial

statistical average. It was to our horror as well. The average age of starts for students in our area is 12. The majority of cigarettes are being purchased through vending machines and retailers. It was a rather disappointing find, I must say, the results of this survey. Anyway, we'll go over some of those results in more detail later on.

But what I wanted to say today was that the council, as it stands, is an interagency council and also encompasses volunteers from the community. We're all on a volunteer basis, actually. Our goal is to achieve a tobacco-free community to protect the health of the community, to reduce tobacco use and to prevent tobacco use. To follow through on that goal, we have developed some resolutions at the end of our survey. I will read those later as we go through my report, but I'd like to make some specific comments on Bill 119.

Other than to say we are definitely as a council in support of what you are trying to do, this is definitely where it is at. Children consider themselves to be 10 feet tall and flameproof. They cannot understand the long-term implications of this addictive drug that they're getting involved with right now. Kids are going to experiment with drugs no matter how much you try to prevent it. They're going to try alcohol; they're going to try nicotine; they may try other drugs as well. But if they can't get it on a regular basis, the chances are they're not going to become heavily addicted before the age of 19. If you can keep them away from it that long, you can probably prevent them from becoming addicted for the rest of their lives. It's paramount. It's the only solution to this long-term problem. Thirteen thousand of our people are dying every year in Ontario, 38,000 in Canada. We have to stop it somewhere. This is the most cost-effective and the best way to do it.

We would like to see Bill 119 strengthened as well. I've outlined some sections on page 2.

Section 3, prohibiting the sale of tobacco to persons under 19: Provincial and local surveys confirm that smoking starts for youth concentrate in the 12-to-17-year range, with the average age in North Bay being 12. Pushing the legal age for tobacco consumption to 19 sends a clear message to our youth that tobacco ranks with alcohol as a substance which needs to be controlled, and that as a community we are taking responsibility to protect our youth from the adverse effects of this addictive drug. I can't stress enough the addiction portion of this drug.

Section 4, prohibiting the sale of tobacco in designated places such as hospitals and pharmacies: The voice in opposition to the banning of cigarette sales in pharmacies is strong. The voice of physicians, pharmacists and other health care professionals warning us of the danger of tobacco consumption is stronger. Pharmacies which no longer carry tobacco products are still in business, and their message to the public is clear: Tobacco kills and is not an appropriate sale item in a retail outlet associated with health and wellness. A clearer definition of the term "pharmacies" would prevent loophole selling in borderline situations where pharmacies are linked to adjacent areas selling tobacco such as those seen in malls.

Plain packaging, section 5: Plain packaging with bold black health warnings is a deterrent to cigarette sales to teens. The current colourful packaging with product logos is eye-catching to the young and often associated with endorsement by authority figures in a young person's life when parents, relatives, peers etc are seen using them. This is the tobacco industry's most powerful advertising technique. Regulations surrounding the packaging of tobacco should be specifically defined to stipulate generic white or yellow colour with bold black health warnings encompassing no less than 25% of the package surface area. In addition, kiddie packages of less than 20 cigarettes should be banned in an effort to keep this product out of the price range of most youth. It was only recently that I found out that one of my children was supplementing their allowance by buying cigarettes and selling them individually at school, \$1 a cigarette. It's a real good way to make money.

Generic packaging with health warnings gives more credence to the serious risks associated with its use. The generic strategy's greatest impact would be on the youth not yet addicted, although some reduction in tobacco consumption by regular smokers in all age groups could be anticipated.

In addition, generic packaging identifies contraband cigarettes by sight, as cigarettes packaged for export would retain their original colour and logos. Kids don't want to be generic; kids want to be bright and different. Having this kind of packaging would definitely have an impact on tobacco sales.

Banning the sale of tobacco from vending machines: As I indicated in our youth survey, 21.4% of our youth are smoking regularly by grade 9, and 76% of those ranked vending machines as the easiest target for buying cigarettes. Although we support the federal government's Tobacco Sales to Young Persons Act, which would restrict the sale of tobacco to vending machines located in licensed establishments, we would prefer to see the provincial legislation, which is to ban cigarettes from vending machines entirely if possible.

We believe that all reports that are made available on the distribution of tobacco products should be available to the public.

#### 1630

Section 9, prohibition of smoking in certain places: The restriction of smoking in designated places such as secondary schools and financial institutions supports the public's demand for protection against environmental tobacco smoke but does not go far enough to define the parameters of the establishments listed. Schools, for example, should be defined as in the Ontario Education Act.

We, as adults, have a responsibility to create a healthy environment for our children. The tighter the controls imposed on the use of this drug in the areas where people congregate, the stronger the message about the negative consequences of smoking. Education itself just isn't going to do it with the youth. They have to be shown. They have to see an example. They have to know that it's not socially acceptable to smoke. If possible, we would prefer to see them having to go right off school property



parameters. The existing legislation could have a big impact on the number of youth who are starting to smoke if it could be enforced. But, unfortunately, there does not appear to be any enforcement—no money, no human power—to enforce what is currently there. If possible, we would like to see the provincial government have some kind of plan which would ensure that enforcement of these new regulations will take place.

In conclusion, Canada is already a world leader in tobacco control legislation. Bill 119, with the amendments suggested here, will support the provincial government's commitment to preventive health care and take the lead in provincial legislation. We are definitely in support of the strong leadership role of the NDP government, and we appreciate and strongly support its stand on not reducing the provincial tax on cigarettes. I understand we are still holding firm on that, although two provinces have caved in already.

**Ms Murdock:** Alberta and BC?

**Ms Palangio:** There's four now? No, I knew Quebec did, and I heard New Brunswick this morning. I'm sure the reduction in tax will have the desired impact. It will probably be a non-violent way to a short-term solution, but the long-term effect will be devastating.

**Mr Wiseman:** I'd like to get this on the record. From your experience at the addiction centre, how soon does a young person become addicted to cigarettes and how frequently do they have to smoke in order to become addicted and at what level?

**Ms Palangio:** Some of the histories we have done indicate that as few as four cigarettes can create an occasional smoker, and the occasional smoker usually at that age will go on to become a regular smoker. It is the same pattern of addiction that you see with any other drug: It is used as a coping mechanism, used to get rid of the pain of social embarrassment or inadequacies the person may feel. Once it becomes successful in that capacity, the addiction starts to develop.

**Mr Wiseman:** So you're saying there has to be a psychological dependency at the same time as the smoking?

**Ms Palangio:** With all addictions there is some kind of psychological component involved as well.

**Mr Wiseman:** So for somebody just trying it for a lark, what would they have to do if they didn't have the psychological component?

**Ms Palangio:** If they were trying it for a lark, the chances are they would not become addicted, if it was a one-time deal and they didn't have a need to use it again: the social pressure or an internal need for it.

**Mr Wiseman:** So peer pressure is enough of a psychological impact?

**Ms Palangio:** Peer pressure can be enough to create the physical addiction. Once the physical addiction has taken hold, it's possible that person may have an easier time getting off cigarettes, but if the psychological component is as well they will have a much more difficult time.

You have people who can quit an addiction immediate-

ly. My husband was like that. "Okay, I'm going to quit tomorrow." Bang, done. Me? It took me two and half years of smoking outside and cheating; like I said, smoking up the chimney. Two and a half years and I finally made it.

**Mr Wiseman:** That's interesting, because I've read a historical thing on veterans returning from South Vietnam. A lot of them had been doing crack and cocaine and marijuana in South Vietnam and some of them came back and off it just like that—

**Ms Palangio:** Because the psychological need was gone.

**Mr Wiseman:** —and others just were trapped. That's interesting to know.

**Ms Palangio:** But the ones we're seeing at the detox are basically the hard-core smokers who are going to have a very difficult time getting off. They are not the majority of the population of smokers, but they're out there.

**The Vice-Chair:** Thank you for your presentation. We're pleased to have it.

#### NORTH BAY AND DISTRICT HEALTH UNIT

**The Vice-Chair:** The next presentation is from the North Bay and District Health Unit. Is Dr Catherine Whiting in the house? Welcome. We used to travel together.

**Dr Catherine Whiting:** Thank you, Ron. I see other familiar faces and some new faces, and certainly a lot of interesting, differing views around the table so I welcome some interesting questions at the end of my presentation.

I recognize too that you've had a long day. I understand I'm second-last on the list and I will try not to put you into slumber, because I don't think this is an issue we should go to sleep about.

The board of health of the North Bay and District Health Unit has a community mandate, as do other health units across the province, to protect and promote the health of its residents. One of the goals of the mandatory health programs and services guidelines is to improve the health of the population by eliminating tobacco use, so I take up Ron's challenge about suggesting that our goal, and this is just the first step, is to actually look at the banning of tobacco.

A three-pronged approach including prevention, protection and cessation is being used to achieve this goal. We must work together to increase the number of the population who have never smoked. In that instance, we're referring to our youth. If they don't start when they're young, the chances are they will not take up smoking when they're older. We must protect the majority of our population who choose not to smoke from the negative health effects of environmental tobacco smoke.

As a mother, my children do not smoke, and hopefully will not smoke if we continue to create an environment that allows them to make that healthy choice. I would be extremely upset as a parent, having given my children the opportunity to live in an environment that is smoke-free, at least at home, to have them exposed in their young life and in their future life to cigarette smoke in other environments.

We must help those who choose to smoke, because the medical interventions for smoking-related illness are either totally ineffective or they're too late.

The board of health for the North Bay and District Health Unit congratulates the government on the introduction of this legislation. This legislation is introduced to reduce the number of young people who become addicted to tobacco and to protect both non-smokers and smokers from environmental tobacco smoke.

I'm going to hold up this report, because we have been trying to get this message across. People just choose not to listen.

As Ontario's chief medical officer of health stated in his Tobacco and Your Health report, reinforced it in his adolescent youth report and reinforced it again in his heart health report, tobacco use is the most important health problem in Ontario and, surprise, surprise, it's the most important health problem in North Bay and district and it's probably the most important health problem in Sudbury.

As the medical officer of health for the board of health for North Bay and district, I'm particularly concerned about the impact of smoking in my area. Nipissing district is lagging behind the province and so is the rest of northern Ontario, particularly in the fight against tobacco. There are fewer non-smokers in Nipissing district compared to Ontario, and I've put the numbers in the report. Correspondingly, Nipissing district therefore has more adult smokers than the province. We have smoking-related standardized morbidity rates and standardized mortality rates that are significantly higher than the province. As a medical officer of health who wants to improve the health of my community, this is not good news.

So what will help us achieve our goal? When I say "us", it's not just people in North Bay; we need the whole province. In fact, I'm sorry to say we need the support of the whole country, but I think we're losing that. What will help us achieve our goal to eliminate tobacco use? Legislation is an important part of a comprehensive strategy. We all know that knowledge does not lead, by itself, to a change in attitude or behaviour. It doesn't matter how many times you take the young person to show them the picture of the lung; it will not necessarily change their attitude about smoking or wanting to experiment and it may not change their behaviour. So legislation is important.

#### 1640

What's another part of the comprehensive strategy? Enforcement of that legislation. What's the point in having legislation if you're not going to do something about it? It's like municipalities having property standards bylaws and not enforcing them. Sorry, I won't get off on another issue.

We need a multipronged approach to ensure success of this legislation. It's an excellent piece of legislation but it doesn't go far enough.

The board of health of North Bay and District Health Unit is very pleased with several provisions in Bill 119. In particular, we're extremely pleased, the whole board,

about tightening the controls on the sales to minors. Why? The majority of people who start smoking start as teenagers. Do you know, if you ask teenagers what they think, they're in a state of denial. Our teenagers are not only invincible; they're infertile, they're immune and they're immortal. How are you going to change that attitude, ladies and gentlemen? With knowledge, with information. We need to have a comprehensive, multi-pronged approach to this issue. I know this, because I talk to my daughter who is almost a teenager and all of this stuff comes out. If we remember back when we were teenagers, sometimes it still carries on as adults.

The city of North Bay in 1993—you already heard about this survey we did, but it's an important piece of information and I want to reinforce it. Our local council on tobacco and health did a survey of grade 7 and 9 students which revealed that 16.3% of our youth reported smoking regularly or occasionally. More importantly, this number of regular or occasional smokers doubled from grade 7 to grade 9. This is just the tip of the iceberg, because as the teens get older the rate of smoking increases with age.

How can we help our youth? And it's our responsibility; we're not going to blame the victim here. How can we help control access to tobacco for our youth? We can do that by tightening up on tobacco retailer licensing. It's very important. Again, the city of North Bay survey by our council on tobacco and health showed that 86.1% of underage smokers found it easy to obtain cigarettes; 48.8% said stores or retailers and gas stations were very easy sources. Another interesting piece of information is that another easy source is that the parents who smoke give cigarettes to their kids who smoke, so we can't forget about the adults in this situation either.

Measures in the act are good, but they don't go far enough to tighten controls on sales to minors. We need to give our youth a clear, consistent message. We try to teach our youth about decision-making tools. Part of that decision-making tool is that they have to have clear, consistent messages and information given to them. We're not doing that as a society, just the fact that we allow cigarettes to be sold in pharmacies. We need to move towards handling tobacco like other restricted and addictive substances. This is a legally addictive drug; it's not M&Ms.

LLBOs and beer stores handle alcohol, our other legally restricted drug. Why not require tobacco to be sold in these same restrictive, controlled settings? Why not give our youth and our adults a clear, consistent message.

Banning cigarettes from vending machines makes sense. No other product that is illegal for minors to purchase is sold through unsupervised vending machines. Again, our survey showed that 18.7% of smokers reported their source as vending machines often, and a further 10.6% reported using them sometimes, and the ones who used them to have cigarettes sometimes go on to be the ones who have them regularly.

Plain packaging would be less attractive to young people, and this has been shown in studies. A recent Canadian Cancer Society study found that more than two



thirds of young people 12 to 15 years said fewer youth would smoke if cigarettes were sold in plain packages.

Another item in Bill 119 that would help deal with access by youth is prohibiting smoking in designated places, including schools and strengthening non-compliance penalties. We were moving forward in our area with banning cigarettes from school property. We have recently had one of our high schools decide they want to change their mind and allow kids to smoke on school property. Please ban smoking from school property. We need this legislation.

These measures will help decrease exposure to environmental tobacco smoke, a known human carcinogen, for both non-smokers and smokers. Sometimes we forget about that. We want to say: "Oh, these smokers, let's stick them all up in a room and make them pay for their health care. Let's just get really angry at them." Well, listen, guys, this is an addictive substance, and we as a society have not done a great job on keeping people away from this addictive substance or giving them a clear message. It was in fact for a long time a very cool thing to do and rather sexy for women too to have a cigarette hanging out of their mouth.

Ontario's Smoking in the Workplace Act of 1990 offers no protection to an employee from an employer who wishes to allow smoking in the workplace. The Ontario tobacco strategy has a goal to eliminate environmental tobacco smoke from all public places and workplaces by 1995. To achieve this goal, the Tobacco Control Act must prohibit smoking in workplaces and public places.

Another good measure which I've alluded to is banning cigarette sales by licensed health care professionals and by putting provincial health warnings on the packaging. I'm not so sure that's going to help our youth because they think they're invincible and immune and immortal. I'm not sure putting the health warning on will help them, but it might help adults who might think, as they get older, that maybe they're not immortal.

We must act now to protect our youth and prevent unnecessary deaths. Believe me, we have more restrictions on alcohol, which causes half the number of deaths in our province, than tobacco. We especially need to move quickly. This government is to be congratulated on this very progressive piece of legislation.

As Canadians, we tend to be unaccepting of what we do well, what we can be noted for. I hope that Ontarians will not follow suit. Ontario has a progressive piece of legislation here to help improve the health of Ontarians. Let's not be traditional Canadians and not carry this forward and cave in to people and lobby groups that don't want us to be particularly forward-thinking and truly have healthy public policy for our people. Of course I'm referring to the recent events around lowering the federal tax on tobacco.

I won't take any more of your time with my formal presentation. There is more in the longer version for you to peruse at your leisure, if you have any spare time, but I will take any questions.

**Mr McGuinty:** Dr Whiting, thank you very much.

There's something that's happening at this time—it's funny how the thinking is evolving, in terms of the general population, about smoking. It's achieved such a level now, it's become so prominent in the media that there may be an opportunity here for this government that it doesn't sense yet and that may not have existed before: that is, to move even further than Bill 119 provides for. It may very well be that our general public feels, probably as a reaction to what has happened at the federal level, we have to do something dramatic to counter that.

**1650**

It seems to me that a couple of ways the government should be seriously considering to tighten this up is that instead of getting into this issue with the pharmacies, which is just nibbling away at the problem, it should be considering putting tobacco in the equivalent of an LCBO. They should be seriously considering fining kids, as we do with alcohol. We restrict its sale and we send a message to kids, so I can tell my 12-year-old: "It's against the law. We feel, as a society, it's so important to protect you from this that it's against the law."

Dr Whiting—as a medical officer of health, I know you'll be concerned about this—right now, two 14-year-olds can sit side by side on a curb, one drinking and one smoking. Which one is subject to arrest if a police officer comes by? Which one has to hide? Who has to be furtive? And which one causes the greater health problems? We're talking about mixed messages here. Those are two ways we could seriously beef up Bill 119.

**Dr Whiting:** The only concern I would have is that we don't just put in blaming-the-victim pieces of prohibitive legislation, that we also move ahead, accepting our responsibility for this problem and not just blame the youth.

**Mr McGuinty:** No. It has to be comprehensive.

**Dr Whiting:** To a 12-year-old who has been given access to messages on television, messages in books that it's okay for adults to smoke, seeing that they're lowering the price of them now, "It mustn't be too bad." We're giving them all these messages. Then they get started on something that's addictive. We have to recognize that this is an addictive drug, just like alcohol. With alcohol, when a youth drinks, gets behind the wheel of a car and harms—both of these drugs have primary and secondary effects, primary effects on the person and secondary effects on others. We need to have a balanced approach to what we do about that. Drinking and driving, yes: If that youth were behind the wheel of a car and drinking, the Young Offenders Act would take over, I believe.

It might be worth looking at something like that, but then you have to decide, at what age is a youth making a truly informed decision about getting hooked on a drug that we're promoting as a society in various ways, and that the tobacco lobby and big tobacco companies are promoting? We're giving such contradictory messages. We do the same thing with alcohol. would hope the next piece of legislation that comes down is something that even looks further at our next big problem, which is alcohol, but let's tackle cigarettes first.

**The Vice-Chair:** Thank you for your presentation.

ALLERGY/ASTHMA INFORMATION ASSOCIATION,  
SUDBURY BRANCH

**The Vice-Chair:** The next presentation is from the Allergy/Asthma Information Association, Sudbury branch, Ms Gregoris. Welcome to the committee.

**Ms Barbara Gregoris:** I should be welcoming you guys.

**The Vice-Chair:** You mean to Sudbury? It is warmer up here.

**Mr O'Connor:** Sharon arranged that for us.

**Ms Gregoris:** So you brought the warm weather up.

**Mr O'Connor:** What happened to your snow? There's more in Toronto.

**Ms Gregoris:** Really? I haven't been down that way in over a month. There's plenty up here for us.

I won't be following the copy of the draft. That's come out of our national office. I present my own bit to offer to you guys. If I get a bit wheezy throughout this, excuse me. I was exposed to smoke twice today and there are still lingering effects. I'm Barbara Gregoris, a member of, and presenting on behalf of, the Allergy/Asthma Information Association.

Bill 119 possesses good qualities. Both the government and the opposition are to be commended for their effort to protect the health of Canadians. However, AAIA, which is the Allergy/Asthma Information Association, believes that the issue of exposure to environmental tobacco smoke has not been thoroughly addressed.

These are the facts: Tobacco smoke kills approximately 40,000 Canadians yearly. Tobacco smoke is a very severe irritant and as such will cause bronchial constriction of the lungs. Therefore, everyone will experience a degree of chest tightness, and those who suffer allergic diseases like asthma or rhinitis are most severely affected. Secondhand smoke exposure is responsible for an estimated 15,000 to 30,000 infections annually in children under the age of two. One in six Canadians suffers from respiratory allergic conditions like asthma or rhinitis. Over 80% of asthma develops prior to a child's third birthday. Secondhand exposure to cigarette smoke is an extremely common trigger of asthma regardless of age, and half a million asthmatic children are made sicker by exposure to tobacco smoke.

Just as a personal perspective for me, I became involved with the association and became interested in this bill because both myself and my 23-month-old son are asthmatics. He's been recently diagnosed, as of September. My husband and I and my son all react adversely to smoke. As a result, before the city of Sudbury placed a smoke-free order on all public places, my family and I would avoid places like shopping malls, restaurants and community events.

Sudbury has a number of great community events throughout the year, but we would have to avoid these places because of the effects on my family's health and on my own health, not only because of the adverse reaction to smoke and our health but out of concern for our young son's safety and wellbeing. For an infant in a stroller or a toddler learning to walk or run, as I'm sure everyone's well familiar with, cigarettes dangling from a

smoker's hand pose too great a risk of an accidental burn to his face. When my son was a newborn, and it was the coldest summer in history around here I think, I was on maternity leave. On two occasions I went into the mall with the stroller. He would be sleeping in the stroller; I'd be moving along. Twice cigarette ashes were accidentally dropped on to where he was sleeping, on to his cover. After those incidents, it just wasn't worth the risk.

It was something I wasn't even aware of until it happened. I guess you don't think at that height level until you have little ones you're concerned about. As a result of that, we've since moved from a stroller to a large backpack. Whenever we go into public situations, even outdoor events, my husband will carry our son on his back where he's well out of the reach of any cigarettes.

For example, just to expand some more on how tobacco smoke affects our lives, when exposed to smoke I begin to wheeze and I lose my voice quite quickly. As a case worker I rely on my voice to communicate to my clients. If I don't have a voice, I don't communicate so hot. My husband's eyes begin to run so badly he cannot see clearly enough to drive, and his sinuses become stuffed up. My son's asthma begins to flare up. Usually we have a three-day bout afterwards trying to just bring things down again. It's not that we want to avoid shopping malls, it's not that we want to avoid restaurants or especially community events—some of the community events around here are great—but the cost to our family has been too great.

#### 1700

Presently, municipalities designate smoke-free areas, but there's no consistency between municipalities on common smoke-free areas. There may be a smoke-free area in one municipality, but in another municipality that same area would be an area where smoking is allowed. AAIA was instrumental in bringing about legislation regarding ingredient listing on food products. Because of that legislation, Canadians know what they are eating. Likewise, we have the right to know whether there will be secondhand smoke before we go, and not when we arrive at a building or at an event.

People have the right to choose the air they breathe, just as they have the right to choose the products they eat. Consistency in smoking regulations would give us the knowledge to make a choice. Adults can make a conscious decision about whether they will be in an area which has smoking. That's a choice they would be able to make.

Children have limited ability to make those decisions. Kids, regardless of age, don't understand that in this spot, in this town, there's smoking, that if we go for a sporting event or a social event we wouldn't be able to go to that same type of area, be it a hockey arena, a sports facility, a shopping mall. How do you explain that to a child of five, that "We're going to have to pass on that this time around"?

We need to ensure that there are smoke-free areas for our children, and that's the main reason I'm here. I hope to have the option, as my son grows older, of teaching him, "These are the places you can go and you know you



won't have to worry about smoke" or "If you go into these types of buildings, these are the areas you're going to have to avoid. But these are the choices of what you can do as a compromise."

To strengthen Bill 119, the association would favour a smoking ban in all public places. This way, it would give people the right to choose.

We would also call for further controls on the issue of smoking in the workplace through amendments to the Smoking in the Workplace Act. There have been several incidents reported to AAIA which indicate that the support to ban smoking at work is becoming more lax.

In conclusion, proactive legislation can save future health care dollars by preventing and minimizing respiratory diseases in all ages. Proactive legislation would also reduce the burden of workers' sick time, school absenteeism and the financial burden of medication costs which families bear. It is hoped that a proactive stand will be taken with the passing of Bill 119, a stand which will protect our children and the rights of those with respiratory allergies to be symptom-free and to prevent the development of the life-threatening chronic disease of asthma. AAIA would request the guarantee of a smoke-free environment in all public places.

**Ms Murdock:** Earlier this afternoon, I think it was someone from Cochrane who made a presentation about having it municipally administered, because every municipality is different. The parliamentary assistant reminded me that under the existing legislation the municipalities have the right to do that right now, if they wish, but your point that it's different everywhere is being made very effectively.

I read somewhere in the full draft you presented, "smoking in public places...unless there is some specific reason for an exemption," but basically, your whole presentation is that there shouldn't be really any exemptions. What kind of exemption would you be suggesting?

**Ms Gregoris:** With regard to exemptions, that would be a compromise, in essence, of a number of places having a smoking area where the ventilation is to the outside area, an area that is separate. Cambrian College here in town would be an example. Their smoking area is a building set way back, vented to the outside, so it's not circulated within.

**Ms Murdock:** So it's not exemptions per se under the legislation, but construction exemptions. Cambrian has that building, but if Timmins didn't have the same kind of facility, it would not get an exemption. That's what you're saying.

**Ms Gregoris:** The concern with a lot of the buildings that have the closed-in—Civic Square is a good example. Civic Square is where our municipal hall and provincial buildings are.

**Mr Wiseman:** Do they recycle the air?

**Ms Gregoris:** Yes.

**Mr Wiseman:** So what you're saying is where they recycle the air there should be no smoking.

**Ms Gregoris:** Yes, because you can't separate that air. Civic Square is a non-smoking building, but there is

smoking in the restaurant. There are two restaurants within the complex, and there is smoking there. Eventually, that smoking filters out into the rest of the common area.

**Mrs Cunningham:** I admire people like you who get involved and try to change things. In terms of the legislation we're talking about today, with regard to preventing the provision of tobacco to young persons and regulating its sale and use by others, we've got all kinds of good information and recommendations to strengthen it. But the legislation you're concerned about is the labour legislation with regard to workplace smoking. I think one of the recommendations of this committee to the government ought to be that this ought to be looked at.

I sat through the hearings and heard from medical officers of health, lung associations, people like yourself who got involved in your community. There wasn't anybody who said the 25% unventilated area would work. We've had it in place now for what, four years? Something like that. Maybe five?

**Mr O'Connor:** A little bit longer.

**Mrs Cunningham:** Whatever. I wasn't the government. The point is that it's got to be changed, and I think a simple way of changing this is just to say, "No smoking in public places." The public is fed up with sitting beside people who smoke, and I think most smokers are now embarrassed. I really believe there's been a difference in the last five or six years and it's time to bring that one to the forefront. Sharon, you could do that. We've heard it here in your constituency. You probably agree with me.

**Ms Murdock:** Oh, yes, I do.

**Mrs Cunningham:** We've heard it a number of times today, we heard it a number of times in London, and I know the rest of the committee members have heard it all over the province. It's time to bring it back. It goes hand in hand with this one, and that would certainly be one of our recommendations.

**Ms Murdock:** That's my ministry.

**Mrs Cunningham:** Sharon's ministry. There you go, we're all set.

**The Vice-Chair:** Thank you for your presentation. We appreciate it.

**Ms Murdock:** Before everyone leaves my lovely riding of Sudbury, I want to thank everyone for coming. It's unfortunate, when we sit on committee, that you never get the chance to see it.

**The Vice-Chair:** Let's face it, we may have further discussion and stay overnight.

**Ms Murdock:** That's true, if something happens at the airport.

**Ms Gregoris:** Which is easy enough.

**Mr Wiseman:** I would like them to invite us back in the summertime so I can enjoy paddling just over the hill here at the canoe club where I used to paddle.

**Ms Murdock:** In a downtown lake that is non-polluted, I might add. I'm very proud of my riding and I'm very happy that all of you have been able to at least appreciate it through the windows. Thank you. Thanks to the staff too.

**The Vice-Chair:** This concludes the hearings on Bill 119, An Act to prevent the Provision of Tobacco to Young Persons and to Regulate its Sale and Use by Others for today.

Mr McGuinty has a question for the committee, apparently.

**Mr McGuinty:** Just a question to the parliamentary assistant or counsel, to clarify something. Would this have application on reserves?

**Mr O'Connor:** In the legislation, you'll note that there are exemption provisions for cultural use. That's how it would apply.

**Mr McGuinty:** But apart from that, it would apply fully on the reserves?

**Mr Jim Wilson:** So all that applies to retail outlets on reserves.

**Mr O'Connor:** As far as I know at this point, yes. We could stand to be corrected.

**The Vice-Chair:** That question will be pursued and a response rendered as soon as humanly possible. The committee is adjourned.

The committee adjourned at 1711.











## STANDING COMMITTEE ON SOCIAL DEVELOPMENT

**Chair / Président:** Beer, Charles (York-Mackenzie L)

**\*Vice-Chair / Vice-Président:** Eddy, Ron (Brant-Haldimand L)

Carter, Jenny (Peterborough ND)

**\*Cunningham, Dianne** (London North/-Nord PC)

Hope, Randy R. (Chatham-Kent ND)

Martin, Tony (Sault Ste Marie ND)

**\*McGuinty, Dalton** (Ottawa South/-Sud L)

**\*O'Connor, Larry** (Durham-York ND)

**\*O'Neill, Yvonne** (Ottawa-Rideau L)

Owens, Stephen (Scarborough Centre ND)

**\*Rizzo, Tony** (Oakwood ND)

**\*Wilson, Jim** (Simcoe West/-Ouest PC)

*\*In attendance / présents*

**Substitutions present / Membres remplaçants présents:**

Murdock, Sharon (Sudbury ND) for Ms Carter

Perruzza, Anthony (Downsview ND) for Mr Hope

Wiseman, Jim (Durham West/-Ouest ND) for Mr Owens

**Also taking part / Autres participants et participantes:**

Ministry of Health:

O'Connor, Larry, parliamentary assistant to the minister

Brenda Mitchell, manager, tobacco strategy unit

**Clerk / Greffier:** Arnott, Doug

**Staff / Personnel:** Gardner, Dr Bob, assistant director, Legislative Research Service



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## Legislative Assembly of Ontario

Third Session, 35th Parliament

## Assemblée législative de l'Ontario

Troisième session, 35<sup>e</sup> législature

# Official Report of Debates (Hansard)

Thursday 10 February 1994

# Journal des débats (Hansard)

Jeudi 10 février 1994

## Standing committee on social development

Tobacco Control Act, 1993

## Comité permanent des affaires sociales

Loi de 1993 sur la réglementation  
de l'usage du tabac

Chair: Charles Beer  
Clerk: Doug Arnott



Président : Charles Beer  
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## STANDING COMMITTEE ON SOCIAL DEVELOPMENT

Thursday 10 February 1994

The committee met at 1014 in room 151.

## TOBACCO CONTROL ACT, 1993

LOI DE 1993 SUR LA RÉGLEMENTATION  
DE L'USAGE DU TABAC

Consideration of Bill 119, An Act to prevent the Provision of Tobacco to Young Persons and to Regulate its Sale and Use by Others / Projet de loi 119, Loi visant à empêcher la fourniture de tabac aux jeunes et à en réglementer la vente et l'usage par les autres.

**The Chair (Mr Charles Beer):** Good morning. We're a little late. The committee was in Sudbury yesterday, so I think that's affecting getting people back in from wherever the time change, wherever they've been. But we are here and look forward to the proceedings today.

NIAGARA REGION  
HEALTH SERVICES DEPARTMENT

**The Chair:** Our first witness this morning is Dr Megan Ward, medical officer of health of the Niagara region health services department.

**Dr Megan Ward:** The lights are on here. Does that mean I'm on?

**The Chair:** You're on.

**Mrs Elinor Caplan (Oriole):** It's all his fault.

**Dr Megan Ward:** Technology's wonderful.

I'm Megan Ward. I'm a physician. I'm the medical officer of health for Niagara region. As the medical officer of health, I serve a population of nearly 400,000 people. My board of health is the regional council for Niagara region, which has 29 elected members. I'm here to speak in support of the Ontario tobacco act.

I'd like to start by giving a perspective of somebody who's worked in public health for 10 years. This has been the issue for everyone working in public health for a very long period of time because of the devastating health effects tobacco has on the health of the population as a whole and on individuals.

Tobacco use is lethal and it's highly addictive, but it's also legal, and we're in this very awkward situation of having to develop tobacco policy for a substance which truly is deadly, widespread, and its use is legal. Tobacco policy needs a long-term vision, a strategy that will eliminate its use in the population of Ontario over time, and I think that long-term vision includes the prevention of young people ever starting to smoke. I think that is the key and I'm a strong supporter of this bill because that's its focus. I congratulate the civil service and the government in bringing forward this act. It's wonderful.

In health departments, we have been focusing for a long time on initiatives which will prevent children from ever starting to smoke. As you know, children begin to experiment with cigarettes in late childhood and the early teen years, actually a long time before they've ever reached the age of reason and are able to predict the effect on their future. They haven't developed cognitively

enough by the time they've started to experiment to know about the health effects,

We have had initiatives for a long time. I think the initiatives that are educational, and environmental support such as non-smoking policies, will be enhanced by this act, which really focuses on the retail of cigarettes and prohibiting it to children.

You're right on target by, first of all, raising the legal age of smoking to 19. We know that if we can get children to 20 without starting to smoke, it is likely that they will be non-smokers for the rest of their lives. So we're working with a generation now, and as we move that generation forward into adulthood, if they are non-smokers, it is also likely that their children will become non-smokers. The age of smokers will gradually increase in the population of Ontario and eventually I think we will move towards a smoke-free society. That's what we want. The health effects are too devastating for this product, and at the same time we have adults who are highly addicted to a lethal substance. The solution for adults is not an easy one. It's not easy to stop, so we need to prevent them from ever starting.

I am also very supportive of having a ban on vending machines for tobacco products and cigarettes. I know this has raised a little bit of a furore for the people who operate these vending machines. However, this is a very easy point of access to tobacco products for children. We are dealing with people who are not yet able to understand the impact on their health in terms of the use of tobacco products. Having free access through a vending machine really is a very negative thing for children. So I support you in the ban on vending machines.

I'd also like to talk a little bit about the prohibition of sale of tobacco in various premises. I know the most controversial one has been pharmacies. My board of health discussed this issue at great length on Monday, and I can tell you that it is in support of the Ontario College of Pharmacists position on this. When the minutes of that meeting become available, I will be forwarding them to this committee, since they do represent 400,000 people on health issues.

1020

I think it is completely inconsistent for a health professional group that is self-regulating to take a position which would promote the sale of a lethal product. It's lethal when it's used as it's intended to be used. I don't think pharmacists can be self-regulating and have a monopoly on the dispensing of drugs and at the same time be retailers of tobacco products. This is completely inconsistent and their college has said this is inconsistent and I support it on that. I understand that they themselves have asked you as the Legislature to legislate the prohibition of sale of tobacco products in pharmacies. I support them, my board supports them, the people of Niagara support them, for what that's worth to you.



Finally, I'd also like to commend both the Premier and the Minister of Health for their strong public stand on the federal reduction of tobacco taxes. They have condemned this position by the Prime Minister to reduce tobacco taxes nationally and they've made early public statements about not following suit to reduce provincial taxes.

We know that children are the most price-sensitive for tobacco products, and probably children and teens are the only people who are price-sensitive for tobacco products in terms of level of consumption. High taxes help children and teens the most. They simply can't afford cigarettes. I think lowering tobacco taxes condemns thousands, and perhaps more than thousands, perhaps hundreds of thousands, of Canadian children and teens to a highly addictive habit, and I think it's wrong. I commend the government on its early condemnation of that.

If I had any point where the Premier and the Minister of Health and the Legislature might push the federal government, since it has decided to lower taxes, perhaps they could push very hard for plain packaging. We also know that children and teenagers respond to elaborate advertising, and particularly product identification on cigarette packaging. Cigarette companies know this too, because they pay a lot of money to have their brand in movies, for example, that children and teens will see.

A plain brown or other wrapper with only words on it will actually go a long way to helping children never start smoking or not smoke enough to become addicted to it. This is a point where the province could push the federal government, since it's taken such a retrograde step in the business of taxation. That's not the concern of this committee directly today, but the province can really help in this.

In conclusion, I support you. I think this is wonderful. The public health community across the province thinks this act is wonderful. I say, "Carry on," and I'm looking forward to it going through the House again and being passed into law.

**Mrs Caplan:** I'm particularly interested in and supportive myself of most aspects of the legislation. I have a concern about one, not that it shouldn't be in here but that it's not going to have the desired effect. One of the things I've heard is that the prohibition on sale in drugstores might just lead to a proliferation of kiosks or having just part of an existing drugstore dedicated and petitioned off, so that it wouldn't have the desired effect of eliminating the sale in or around drugstores; it could have the opposite effect. Have you or your board considered that or heard of that as a result of the legislation?

**Dr Megan Ward:** I'm not sure that's quite on the point, to be honest, in the sense that this act is in no way going to prevent the sale of tobacco products. It is legal; it is a legal substance; the sale of it is legal. The issue is whether or not health professionals who benefit from having a monopoly in one aspect of the provision of health care should be selling lethal products. Their college has said no. But tobacco products are going to be sold. Personally, I strongly support, as does my board strongly support, the position of this particular group of health professionals that it not be in their retail space.

**Mrs Caplan:** I was actually quite encouraged. An

article in the Ontario Pharmacists' Association magazine said that almost 40% of pharmacists agree with the position that pharmacists should not be selling—I think it was 37%, 38% or 39%—and that about 62% were concerned because of (1) the economic interest and (2) because it wasn't going to reduce access, as you just stated. In fact, they saw it more as window dressing. But I was encouraged that 40% of pharmacists believe that pharmacists should not be selling and benefiting—

**Dr Megan Ward:** We have surveyed our pharmacists in the Niagara region and there are very few who have any trouble at all with the idea of eliminating tobacco sales from their pharmacies. What they're most interested in is that all their colleagues have also eliminated tobacco sales from their premises.

**The Chair:** Both Ms Cunningham and Ms Haslam say they have short, sharp supplementaries, and when they say they have short, sharp supplementaries—

**Mrs Dianne Cunningham (London North):** We are both unbelievable, I'll tell you that, but we got on.

**Mrs Karen Haslam (Perth):** What he's saying is, in a pig's eye.

**Mrs Cunningham:** I was keen to ask a question, because I think it's great that the medical officers of health have come forward during these hearings. Some of them have been quite—what should I say? They're very ahead of their time in thinking. We heard from the medical officer of health of North Bay in Sudbury yesterday, and in London on Monday from the medical officer in the Essex-Windsor area. Both of them said that we should consider licensing stores that sell tobacco, because this is a proliferation of the present system and we don't enforce it. There are fines now for people who sell to minors.

They've gone so far to say we should consider licensing and they have gone so far as to say that we should be selling cigarettes in LCBO stores and taking them right off the public market. The medical officer of health in Essex said that we should start fining young people. I just wondered if you had had any of those discussions within your own unit, because those are the kinds of things we have to think about, in my view.

**Dr Megan Ward:** I also strongly support the concept of licensing. That takes some work to put together. You've got sort of the first piece of the puzzle here, as far as I'm concerned. I think licensing would deal with some of the enforcement issues very well and could easily be another piece of this whole strategy that would be very helpful. Similarly, having tobacco sales in designated outlets does the same sort of thing. Again, we're focusing on children and young teens. This is the target group. This is the kind of thing that will prevent access until they become capable of making their own decisions. That takes some work to put together and I think that would be an extremely helpful process to go through, extremely helpful.

**1030**

**Mrs Haslam:** Mine's even shorter. On page 4, "A University of Minnesota study found that teenagers aged 14 to 15 successfully purchased cigarettes from vending

machines, including those in bars and clubs, 82% of the time." Are you aware of any other studies? I was really pleased to see this one. It's the first time we've seen a study alluding to the availability of cigarettes in vending machines.

**Dr Megan Ward:** No, not in terms of the published literature, I'm not.

**Mrs Haslam:** What about unpublished?

**Dr Megan Ward:** We have looked at that very issue and have found that they are definitely able to get access in this way. It's a key way for them in our region.

**The Chair:** Dr Ward, thank you very much for coming today and for your submission. We appreciate it.

CANADIAN CANCER SOCIETY,  
METROPOLITAN TORONTO REGION

**Ms Sandy Bassett:** I'm Sandy Bassett. Thank you for the opportunity to speak about Bill 119. I am one of 500 volunteers who work with the Canadian Cancer Society in Metropolitan Toronto. I co-chair the health promotion committee for Metro Toronto and in this capacity I work with many volunteers who try to raise people's awareness about the relationship between lifestyle and health.

We talk to people about the four key messages of the society which can greatly reduce their risk of cancer. We talk about diet and healthy food choices; limiting exposure to sun; breast health, especially breast self-examination; and abstinence from tobacco. This committee's review of Bill 119 presents an excellent opportunity for the Canadian Cancer Society to reinforce its message about the dangerous effects of tobacco.

I also appear before this committee as a mother of two young boys who I pray will never have to experience the addiction and devastation of tobacco, and as a nurse who has seen the pain and suffering experienced by patients and their families. I also appear as a daughter whose father died less than a year ago from lung cancer after a short, nine-week battle.

My father smoked a pack a day from age 14 until his untimely death at age 63. What really saddens me is that his death was completely preventable. My father was addicted to tobacco and tried to stop many times. He tried cold turkey, gradual reduction and hypnosis, but the nicotine addiction was too strong to overcome, despite his genuine desire to stop smoking.

I am accompanied today by Jeffrey Brewster, a university student who smokes and whose attempts to quit smoking have been unsuccessful to date, despite his mother's recent diagnosis of lung cancer. Jeff wanted to share with you his views about the perils of smoking and his thoughts about the need to restrict its sale and use. Like me, Jeff has experienced cancer in his family. We both know the anxiety that comes with the diagnosis and we are both here today because we believe so strongly that everything must be done so that others do not have to face cancer themselves or in their families.

In a few moments, I will ask Jeff to speak to you. However, I would first like to take this opportunity to congratulate the government for introducing legislation that will protect the public from the harmful effects of tobacco.

A 1990 survey found that smoking was more prevalent among people with lower education and income, and this provides some evidence that non-legislative attempts to reduce tobacco consumption have not been uniformly successful. We cannot ensure that health promotion programs affect everyone equally. However, we can be fairly certain that everyone is equally affected by legislation. Legislation which controls tobacco use does not recognize differences in education, income level or employment status. It is applied equally across the population and has the potential and the power to effect the same outcome for everyone in Ontario.

There is no disputing the evidence that links tobacco consumption to cancer and premature death. Yet tobacco is the only legal product that, if used as directed, will lead to disease and death.

I find the statistics I'm about to review particularly disturbing because they highlight the extent and seriousness of tobacco use among the youth of Ontario. A number of statistics are noted on page 3 of my submission. However, I'm only going to speak to the three which relate to tobacco use among teens.

We know that if people smoke before the age of 20, they are more likely to become addicted to tobacco. Yet from 1991 to 1993 smoking among students in grade 7 increased by 50%. Currently, almost 10% of grade 7 students smoke. These kids are not even old enough to drive, yet they are old enough to be addicted to nicotine.

We know that tobacco is highly addictive. The Ontario student drug survey, from 1977 through 1993, found that among teens who tried to quit, 46% could not remain abstinent for more than one week. In addition, the Addiction Research Foundation noted that between 1991 and 1993 the percentage of young people trying tobacco for the first time before grade 9 increased from 69% to 75%.

We know also that in Ontario, 3,000 new adolescents begin smoking each month. If we are ever to achieve our goal of a smoke-free generation, we have to restrict youth access to tobacco.

I will ask Jeffrey to speak about his own tobacco use and his thoughts and concerns about Bill 119.

**Mr Jeff Brewster:** Hi. My name's Jeff Brewster. I've been smoking for seven years and I've tried to quit a few times. I was able to quit for four months at one point, but I ended up going back. I don't buy cigarettes myself in pharmacies; I usually go to the corner store. I'm pro this bill because I don't believe pharmacies should be selling tobacco products, for reasons that have been stated here and stuff like that.

Obviously, when my mom was younger there was not much legislation to stop her from smoking. Kids had a lot of access to cigarettes when they were young. They didn't realize what they were getting into, obviously. A lot of older people now have cancer and a lot of them are related to cigarette smoking and stuff like that.

I found it really hard to accept the fact that my mother had cancer and hearing her hacking and coughing and going to chemotherapy and seeing her go through all the side-effects of stuff like that. It's scary and I feel that any legislation that will allow fewer people to smoke and give



them a chance of not contracting cancer themselves will be beneficial to society as a whole.

**Ms Bassett:** Thank you, Jeffrey, for your sincere and candid reflections as a young smoker. Your comments highlight for all of us the personal consequences that smoking has on oneself and on one's family.

Jeffrey and I believe that our government has a responsibility to translate the evidence we have about tobacco-related disease into legislation that will alter behaviour and serve the public good. We also believe that Bill 119 is an effective way to restrict access to tobacco, limit the influence that tobacco manufacturers have on children and ensure that those who provide the public with tobacco exercise that privilege responsibly and within the limits of the law.

On pages 4 and 5 of my submission, a number of important recommendations are listed. However, I will only speak to a few of these, again as they relate to the youth of the province.

Section 3, which effectively restricts access to tobacco by raising the legal age to 19, is vital to decreasing the incidence of addiction. This is especially important in light of the fact that people are unlikely to become addicted after the age of 20. However, the requirement for proof of age should not be contingent on the purchaser appearing to be less than 19 years of age. As currently stated, this section allows the vendor excessive discretion, and in practice could contradict the intent of this provision.

Section 4, prohibiting the sale of tobacco in designated places, particularly pharmacies, is critical to the integrity of this legislation. Pharmacists are unlike other vendors. They are health professionals, as am I. However, they have an exclusive right to dispense drugs. This right is accompanied by a responsibility to advance the health of their patrons. By selling tobacco, pharmacists convey an implicit message that tobacco is in the same category as other goods sold on the premises. The legislation must clearly define the term "pharmacy" in order that there be no opportunity to use a technicality to circumvent the law and defy the intent of the legislation.

1040

Section 5, regarding packaging, health warnings and signs, is central to limiting the influence we know tobacco manufacturers and vendors have on our vulnerable consumers. Tobacco companies should not be allowed to capitalize on our naïve and unsuspecting youth. If government is serious about reducing tobacco consumption, it can make a very strong statement by ensuring that tobacco products are clearly differentiated from normal consumer products.

Cigarette packaging is designed to attract young people and convey an image. For young people, the package they carry is similar to the clothing they wear or the knapsack they carry. It becomes part of their identity and a means to position themselves with their peers.

Research funded by the Canadian Cancer Society and carried out by the Centre for Health Promotion at the University of Toronto indicated that if cigarettes were sold in plain packages, fewer children would smoke.

Further, the plain package would confirm the serious nature of the contents and make the health warnings more evident. It breaks the link between the cigarette package, the act of smoking and the exciting activities portrayed in tobacco advertisements.

We recommend that the regulations also ensure that explicit and clearly presented warnings on the exterior and interior of the package will help to meet the consumer's right to know the harmful effects of tobacco.

The regulations under this section must also prohibit the sale of kiddie packs, or packages of fewer than 20 cigarettes. We know from research that teens are very price-sensitive. The tobacco companies know this too. It is a marketing strategy they use to encourage young people to buy a product which can ultimately kill them. The lower cost associated with packages of reduced size will undoubtedly increase the availability of children to purchase cigarettes.

In addition, the sale of promotional paraphernalia such as cigarette cases must be prohibited. Such items could undermine section 5 by permitting the sale of an item which depicted brand name and logo and conveyed no health warning.

Section 7, banning the sale of tobacco in vending machines, must remain in the legislation. Without this control, children would have easy access to tobacco. They would not have to show proof of age. They would not even have to be tall enough to reach a counter. It seems to me that if the city of New York can ban tobacco vending machines, then the province of Ontario can do as well. Tobacco should not be as easily accessible as is a chocolate bar or a bag of chips.

In conclusion, we would like to thank this committee for considering our recommendations. We trust that your deliberations will result in powerful, progressive legislation which places health above all other concerns. However, so much of what we are trying to achieve could be diluted by the rollback in taxes. We applaud the government for its strong stand. However, the government will need to reconsider licensing as a measure to control the sale of tobacco.

We trust that as a result of this legislation, the tobacco-related cancer statistics that we review in the future will differ dramatically from the ones we note today. We look forward to the early passage and proclamation of this bill.

**Mrs Cunningham:** Thank you very much, both of you, for coming here today. Your presentation was very personal. We've heard a fair bit of it and I think it enhances the real need to be strong with this legislation.

I was pleased that you pointed out the need for regulations with regard to the plain packaging, and I'd ask you to speak to the fact that I think that probably ought to be in the legislation as opposed to regulations. If you can ban vending machines, maybe you can ban the cigarettes that aren't in plain packaging and also the kiddie packs. I think they should both be in the legislation.

I also wondered what you would do with regard to (3)(a). Right now—you probably heard me before—I feel very strongly that people should take responsibility for what they do. If they're breaking the law by buying

things that they shouldn't, they should be penalized in some way, maybe by community work. What right has the vendor got to ask for proof of age, or should we be writing that in the legislation as well? How would it work? Those are two things I'm asking you, obviously, to strengthen the legislation.

**Ms Bassett:** I would certainly personally agree with strengthening the legislation. Licensing is a very important way that we can use to control access to youth. That's really what this legislation is aimed at.

**Mrs Cunningham:** Right; I agree.

**Ms Bassett:** As we mentioned earlier this morning, we're not going to ban the sale of tobacco completely. What we really want is to—

**Mrs Cunningham:** Control it.

**Ms Bassett:** —aim for a smoke-free generation.

I believe the plain packaging should be in the legislation. It is an image issue for teenagers. They will not want to be seen with a package of cigarettes that is uncool, that looks ugly, that is—

**Mrs Cunningham:** In buff packages.

**Ms Bassett:** —in buff. I think that's really important.

In terms of the vendor's responsibility, in preparing for today, one of the briefs that I read talked about that children are less likely to smoke if they are turned down on their first attempt at purchasing it in a store. That in and of itself is very significant.

**Mrs Cunningham:** Do you think we should be asking for proof of age?

**Ms Bassett:** Yes. I think there should be some method, whether we use our age of responsibility card or something else.

**Mrs Haslam:** I was very interested in your comment about lower education and income and the incidence of smoking. The probable result of what Mrs Cunningham and I have been talking about is the apparent lack of change through education processes, and that makes me very pessimistic about the federal government putting more money into an education program when statistically it's shown it's not working effectively. I would rather see the \$200 million go into some other form, so I'm pleased to see you've mentioned that.

What interested me also, on the last page of your presentation, is that you're the first group that's really come to us and said that you would like to see section 15 strengthened, looking at the penalty. I say "the first group" because most other groups come and say, "We would like you to go to a licensing idea and a licensing proposal."

Would you just comment, is this your second choice? "If you're not going to go to licensing, then we'll comment on what's in the legislation. If you stick with that, we would like to see some higher penalties, some longer length of time." Or is your priority licensing? Could you comment on that?

**Ms Bassett:** I think it's vital. The way the legislation is currently written, we do have to have stronger penalties. It won't be effective without that.

Licensing would be the first choice. I think, though,

that perhaps we thought we would try strengthening section 15 and then, as I mentioned in the very last, if the tax rollback takes effect, then we do really have to reconsider this whole licensing aspect.

**Mrs Haslam:** Actually, I couldn't agree with you more. I think a lot of us are now looking at the legislation saying, "We could have maybe been a little more hopeful out of this legislation, reaching our goals," but now since the federal government has done what the federal government has done, looking at our legislation and our goals, we really have to rethink some of the clauses here. I appreciate your bringing that forward.

**The Chair:** Thank you very much. I'm sorry for the time problem, but we appreciate you coming before the committee today.

KATHLEEN LEACH

**Ms Kathleen Leach:** I'll be very brief. I decided to come here today. I'm an independent community pharmacy owner. I was concerned that the impression this committee might be receiving was that pharmacists support the sale of tobacco in pharmacies. I do not support the sale of tobacco in pharmacies, and I wanted to make sure that my voice was heard.

**Mrs Caplan:** If I could, what is the number, do you know, of pharmacists who do not support it? Did you see that article?

**Ms Leach:** It's difficult, because we're running into a problem where you look at pharmacists or pharmacies. Many pharmacies are governed by a corporate image which imposes beliefs on them that they don't necessarily hold themselves.

I've long advocated the removal of cigarettes from pharmacies. I consider myself to be a smoker. Even though it's been a long time since I've had a cigarette, it never goes away.

In 1990, I was successful in convincing the previous owner of my business to cease selling tobacco products. I did that by coming in on my day off and getting a stopwatch out and keeping track of exactly how long his staff spent, actually timing the amount of time a person sold only cigarettes, counted only cigarettes, ordered only cigarettes, and then I asked him if it was really worth his while to sell cigarettes. So on January 1, 1991, we stopped selling tobacco. I felt it was inconsistent with health promotion.

1050

Initially, I supported my association's views of voluntary cessation of sales, but the tobacco lobby is much stronger than the will of individual pharmacists, and unfortunately we haven't been able to meet our goals in that manner. It's time for a legislated removal of tobacco products. It should be from all retail establishments, including pharmacies.

We have a distribution network whereby we could sell them through government-controlled stores and the government could use the profits to support health care, as opposed to private business obtaining the profits of tobacco. If it's going to continue to be sold in Ontario, I think that's a route that should be considered.

I want to share with you a little bit of the business



impact of removing tobacco from my drugstore. Prior to removing tobacco, sales were growing in the store at approximately 10% to 12% annually. In the first fiscal year following the removal our sales increased 4%, so we did not see a decline but we did see a slower rate of growth.

Gross margin declined 1.3% and net profit declined exactly \$1,251. It's absolutely negligible. That's not going to harm any pharmacy whatsoever. The decline in gross margin and net profit can be attributed to other economic factors which I have outlined. In the second fiscal year following the removal of tobacco sales our sales actually increased 10.4%. So we were back to our normal rate of growth within one year.

We didn't replace tobacco with any other product. Some are saying, "Get into home health care, get into this, get into that." All we did was start paying more attention to our customers. We increased our customer loyalty and we increased our credibility with our customers.

Lots of people will also come here and tell you that tobacco is a legal product and that therefore they should have the right to sell it. Alcohol is a legal product; I can't sell it in my store. Valium is a legal product; I can sell that in my store but a lot of other people can't because there are a lot of rules and regulations that go along with selling it. Those kinds of precedents are very apparent for the tobacco issue.

I don't think it goes far enough. As I said, I think we should totally restrict the sale to Ontario government stores.

I can tell you that I acquired the cigarette habit in high school. I bought all my cigarettes at the Tamblin's drugstore right next to my high school, and when I was in university I bought them all at the Shoppers Drug Mart that was conveniently open till midnight, even when I ran out at 11. I probably still would have tried smoking in high school, but if accessibility had been a lot less possible, I would probably not have continued to smoke as long as I did. In 1983 I quit a very heavy-duty habit and, as I said, it never goes away, because that only lasted two years and I had to quit a second time.

I think our profession has to make a very important decision as to whether we're retailers or professionals. This is the opportunity to demonstrate that we are professionals, and that's why I'm here. I'd like to thank you for your time, and if you've got any questions I'd be happy to try and answer them.

**The Chair:** Thanks very much for coming to the committee with your personal history. We have time for a couple of short questions.

**Mrs Yvonne O'Neill (Ottawa-Rideau):** I'm interested to hear the results of your study when you did the stopwatch. That's certainly a novel way and the first time we've heard of an employee helping an owner make the decision. If you could, just tell me what your experience is with the pharmacy that sells tobacco asking for ID from minors.

**Ms Leach:** I really don't have the results from the stopwatch study. I did it for two days. I never thought I'd

need them. They were on a scrap piece of paper and they went straight into the garbage when it was over. All I remember is that as to the concept that tobacco sales create traffic and draw people into the pharmacy, it became more and more apparent to the owner that people were only buying cigarettes. They weren't buying other things. They weren't getting their prescriptions filled at our drugstore. Therefore, it's a misnomer that it creates traffic and that it helps your business.

As far as being carded is concerned, so to speak, when I purchased cigarettes as a minor: never once.

**Mrs O'Neill:** Did you feel the store you work in was responsible in that respect?

**Ms Leach:** Very, yes. I'm in a very old neighbourhood, so there are very few minors in the area.

**Mrs Cunningham:** Your persistence in the world of work really paid off. It does sometimes here too.

I was interested to see that you have taken the strong stand that tobacco should be distributed just like alcohol through government-run monopoly stores. I can tell you that more and more people are saying that. What would that do to the business in your community, for instance, not just your drugstore but around you? Not that I'm that concerned about it, but I thought since you're so observant, you might tell me maybe the downsides, if there are any. I don't know.

**Ms Leach:** Having spoken to other business owners, both pharmacy and non-pharmacy, who sell cigarettes, I've been told recently that there is no money in tobacco any more unless you live in the States, because that's where it all comes into Canada from. I don't know what's going to happen after yesterday, but something that's not in my comment is that Ontario should not lower tobacco taxes regardless of what happens federally. People have said that the tobacco is there, that it does create a bit of a traffic problem, but if we don't have it they're still going to come in for their bread and milk. The actual profitability of tobacco in and of itself is minimal.

**The Chair:** Thank you again very much for coming before the committee this morning.

MARGARET FRANKOVITCH

**The Chair:** I then call on the representative from the Brooklin Pharmacy, Peggy Frankovich. Welcome to the committee, Ms Frankovich. You have distributed a copy of some material, which committee members have. Please go ahead with your presentation.

**Ms Margaret Frankovich:** I think it's just going to be more of the same, but —

**Interjection:** We love it.

**Ms Frankovich:** Okay. As a pharmacist and pharmacy owner in Ontario, I would like to voice my strong support for Bill 119 and to applaud the government for the introduction of this legislation. I have appeared before the committee before as a founding member of the group Pharmacists in Support of Bill 119, but I'll just remind the committee of my background.

I've been an active practising pharmacist in Ontario for 22 years and I have owned a community pharmacy in Brooklin, Ontario, for the past 10. Previous to moving to

Brooklin, I practised community pharmacy in north-eastern Ontario, where I had the opportunity to work at the Northeastern Regional Mental Health Centre and to work with the Addiction Research Foundation.

I am presently the coordinator of continuing education for the Durham Region Pharmacists' Association and I'm one of those pharmacists who is absolutely committed to pharmacy as a health care profession and to pharmacists as members of the health care team.

Our pharmacy is located in the village of Brooklin, which has a population of approximately 2,000 people. We are the local community pharmacy. We have not sold tobacco products since the end of 1983. We are very happy with our decision and we have been given a great deal of support from our community because of this decision.

In coming before the committee as an independent pharmacist-owner, there are three areas that I would like to address: pharmacy closings, potential job losses and the pharmacist's intervention in tobacco cessation techniques.

To support my position that pharmacies will not necessarily have to close because they stop selling tobacco products, I have enclosed copies of sales figures from our financial statements from 1982 until 1985. We stopped the sale of tobacco products at the end of 1983. As you can see, our sales did not decrease as a result, although our gross margin did decline slightly in 1984. I have enclosed our sales figures for 1992 simply to indicate that after 10 years we are continuing as an economically viable pharmacy.

Because not all pharmacists will be able to appear before the committee, I thought it would be appropriate to have another example. Another pharmacist-owner has agreed to share his financial data with the committee. This pharmacy ceased the sale of tobacco products January 1, 1991. You will notice that his total sales did decrease slightly in 1992 but gross profit did not, and his projected sales for his year-end 1993 are up.

These are two examples where community pharmacies were able to stop the sale of tobacco products and still remain viable in their community. May I also mention that in neither of the above cases did any employee lose his or her job because of this action.

I do not wish to imply that the loss of tobacco sales will not affect any pharmacy in Ontario. There may be pharmacies with high tobacco sales on which this legislation will have an adverse effect, but I urge the committee not to let this dissuade it. Pharmacists are health care professionals and pharmacies are health care facilities and cannot be involved in the sale or promotion of a product which causes such morbidity and mortality to the people of Ontario. To function successfully as members of the health care team, the public must see our profession as one which has their best interests at heart, and selling tobacco products does not do that.

1100

I have listened to some of the presentations and was interested to hear that some pharmacists would have you believe that you can best counsel people about stopping

smoking if you have tobacco products for sale in your pharmacy. Let me assure you that even though we do not sell tobacco products, we regularly counsel people on techniques for stopping smoking. It is because we promote ourselves as a health care facility that people ask for advice. It is certainly not because they see cigarettes in our pharmacy and therefore expect us to know about smoking cessation techniques.

I thank you for giving me the opportunity to state my position and that of other pharmacists like me who believe that this legislation is important in both the fight to improve the health of this province as well as the stature and profession of pharmacy.

**The Chair:** I'd just note for the record that you have attached a variety of statements with respect to the costs and so on. Those are all there and I'm sure we'll find them interesting to look at.

**Mrs Caplan:** I personally agree with you. I don't think that any health professional should benefit economically from the sale of a product which is so lethal and has such adverse impacts on the individual's health, even though it is a legal product.

I'm wondering whether you think there should be a statement in the legislation that says it is professional misconduct for any health professional to sell tobacco products or to benefit economically from the sale of tobacco products.

**Ms Frankovich:** That's an interesting concept.

**Mrs Caplan:** I'll give you the example. One of the things I've heard is that it's likely you will see a proliferation of kiosks selling cigarettes. It would seem to me that you could well have a health professional who owns a kiosk and that this would be as much anathema to the health profession in their professional responsibility. Someone had suggested to me that perhaps you should have a statement about it being professional misconduct to benefit economically from the sale of tobacco, and I wondered what you thought of that.

**Ms Frankovich:** I think it might be difficult to legislate. I believe the Ontario College of Pharmacists will be addressing the concept of kiosks and the partitioning off of sections in the pharmacy, so I believe they will address that.

**Mrs Caplan:** That's only as it relates to pharmacists. What about other health professionals who might have an interest in a kiosk?

**Ms Frankovich:** I truly believe that no health professional should benefit from the sale of this product. Whether or not it can be legislated, I'm not sure.

**Mrs Caplan:** That's my question as well. Thank you.

**Mr George Dadamo (Windsor-Sandwich):** As a reformed smoker two and a half years ago, as a father—my father died from lung cancer at 64 in 1979—it's easy for me to talk about, and I think that we should go a long way. Should we take the sale of cigarettes from private and perhaps bring it to a monopoly kind of forum in government-run stores?

**Ms Frankovich:** Many pharmacists would support this concept. They feel this product is a lethal and



dangerous enough product to be sold under such strict control. That is certainly something the committee could look at.

**Mr Dadamo:** I only bring that up because some European countries do that now, sell them only in government-run stores.

Do we go far enough to educate the kids in schools as to the bad effects of this? Should there be curriculum?

**Ms Frankovich:** More work could probably be done there. I'm a believer that the new smokers are these young people, even in public school, and probably more work can be done in this area in education.

**The Chair:** Thank you very much for coming to the committee today. We appreciate it.

#### CITY OF SCARBOROUGH

**The Chair:** We're now going to put together two presentations by the City of Scarborough. I welcome Mayor Trimmer and her associates. They've requested to make their submission together, and then we'll follow that with questions, if both the city and the public health department would come forward. Welcome, all, to the committee.

**Mrs Joyce Trimmer:** I'm going to sit at the end, because I will not be the main presenter today. I have just come from another of your committees and made a presentation on the secondary units. It turned into quite a ruckus and I'm still about two feet off the ground. The work has all been done by the chairman of our board of health and our staff, our MOH and deputy MOH, so they are going to carry the ball on this one. Then, if I may, at the end if I feel there's anything I can add to their arguments, I will have my two cents' worth then. I'm very supportive of everything they have been doing.

**The Chair:** Perhaps you'd be good enough to introduce the other members, whoever is going to present, and please go ahead.

**Ms Sandra Pritchard:** I'm Sandra Pritchard and I'm the chair of the Scarborough board of health. With me are Dr Zofia Davison, our medical officer of health, and Dr D'Cunha, who is the assistant medical officer of health as well as the chairman of the medical officers of health of Ontario.

I have come more as just representing the chair of the board, and these people will give you the gist of our presentation. Scarborough council has before the Legislature a private member's bill to help regulate smoking, particularly to ban that in Scarborough, and we don't feel it's within our jurisdiction just to do all of that. We are asking your support in that. Somewhere in the system is this private member's bill.

We in Scarborough have worked very hard through the years, all our staff and all our people, to get a grip on the smoking problem, especially with the younger people, and we felt we were starting to make a bit of headway. We're very concerned now, and we would like you to really think very strongly about what our people here are going to be presenting to you.

**Dr Zofia Davison:** Good morning. I'd like to begin by commending this government for introducing this significant piece of tobacco control legislation. I hope the

opposition parties are supporting it, since this is a high-priority health issue and deserves non-partisan support.

The evidence of the enormous damage done by tobacco to our population's health has been clear for decades, yet we continue to battle on this issue. The public health community, of which I am a member as a medical officer of health, together with other health professionals and their various organizations, have all been fighting for this kind of legislation for a long time and stand behind the province in this matter.

The issue we cannot lose sight of is that tobacco kills more than 13,000 Ontarians each year, 6,000 from heart disease alone and others from diseases such as cancer, respiratory disease and low-birthweight babies born to smoking mothers.

With respect to the legislation itself, I want to make three main points. First, it is very appropriate that its key emphasis is on reducing tobacco use in children. I strongly support the bill's measures to reduce access to young people, including raising the age for the purpose of tobacco sales to 19, posting health warnings as well as minimum-age requirements at retail locations where tobacco is sold, and banning cigarette vending machines.

I would go even further. Bill 119's provisions should be strengthened by:

- Implementing a licensing system for tobacco retailers.

- Prohibiting the sale of kiddie packs of fewer than 20 cigarettes to reduce low-cost tobacco targeted to children and adolescents. Other provincial governments have taken steps in this direction, including Nova Scotia and Prince Edward Island and, I understand, the government of British Columbia.

- Packaging cigarettes in plain packages. A recent Canadian Cancer Society study concludes that young people are less likely to start smoking if cigarettes are sold in ugly packages as opposed to the attractive packages innocently designed to look like candies or any sort of condiment that one can consume.

#### 1110

I'm deeply concerned, as undoubtedly you've heard from others, about the federal tax rollbacks and lower-cost tobacco since their impact will be primarily felt by children. This makes a strong Bill 119 all the more essential. We know that children are risk-takers and that children who start smoking stay hooked on the habit and years later become part of our heart disease and cancer statistics. We must do everything possible to prevent this addictive and life-threatening behaviour in our young people.

Specifically with respect to sales of tobacco in pharmacies, the province is showing great leadership in responding to the Ontario College of Pharmacists' request for a ban on tobacco sales in pharmacies; 8,200 pharmacists and 2,000 pharmacies support the bill as well, and independent pharmacies in Scarborough are choosing to ban tobacco sales voluntarily in their pharmacies, given the obvious incompatibility of selling tobacco with providing health services.

One of our local pharmacists states, "How is it that a

child can understand the contradiction between selling tobacco and providing health care, but adults are blinded by the financial bottom line?" Another local pharmacist said he does not sell tobacco products because he feels he's promoting poison. It is noteworthy that both of these local pharmacies continue to survive economically.

Finally, with respect to environmental or second-hand smoke, Bill 119 addresses this important issue, but it could go further to ensure that Ontarians are protected against the detrimental effects of second-hand smoke in both workplaces and public places. The hazards of second-hand smoke are well documented. As outlined in the provincial medical officer of health's report, Tobacco and Your Health, second-hand smoke has been linked to such illnesses as lung cancer in non-smokers and respiratory problems in young children and infants.

I would also urge that the smoking-in-the-workplace act, which is largely ineffective, be improved. Currently, there is no definition in that legislation of a designated smoking area, thus allowing employers to comply with the law by putting smokers and non-smokers on separate sides of a single room. Moreover, the Smoking in the Workplace Act does not require smoking and non-smoking areas to be independently ventilated.

I would also urge that the list of designated public places where smoking is proscribed in Bill 119 should be expanded to encompass all enclosed public places such as shopping malls, recreation centres, theatres and cinemas, restaurants and fast-food outlets.

I again would refer to the leadership of our board of health and our city council, spearheaded by our mayor, with respect to the proposed bylaw, which is now going through the process in the Legislature of getting enabling legislation. It is the strongest bylaw in Canada. It bans smoking in local workplaces and enclosed public places. A copy of the bylaw is attached to the submission that we've given to you.

We ask for your support in getting the enabling legislation. We would also emphasize, however, that individual municipal efforts are not enough and we call on the province to strengthen Bill 119 with respect to smoking in public places as well as strengthening the workplace act.

In conclusion, I would congratulate this government first of all in looking, during these tough fiscal times, at how to maximize our population's health while minimizing costs. The whole health care reform issue is before you. You would be absolutely correct in putting tobacco use prevention as the highest priority health issue to be addressed by prevention initiatives that are not associated with high-tech costs. If you do a cost-benefit analysis you have a preventive measure that will have the greatest impact on the public's health, and you will not be incurring hospital, OHIP or other technology costs.

The landmark piece of tobacco control legislation will make a major contribution to the health of Ontarians. We call on all MPPs to vote yes to this legislation and to capitalize on the opportunity to augment its effectiveness by strengthening its provisions.

I thank you, and all of us are available to answer

questions. If don't know if the mayor would like to add any comments.

**The Chair:** I think there are a number of questions, but Mayor Trimmer, did you wish to comment?

**Mrs Trimmer:** I'd like to reiterate a couple of points and maybe add a couple of my own, if I may, just to remind everyone that tobacco does kill more Ontarians than die as a result of murders, accidents, suicides, alcohol, alcohol-related traffic fatalities, illicit drugs and AIDS combined.

The British Royal Society compares the tobacco epidemic to cholera epidemics of the last century. Tobacco is as addictive for some smokers as heroin or cocaine, and yet over 3,000 children join the tobacco market each month in Ontario. I would also add that the use of tobacco is growing among young women, and that is particularly disturbing.

I think it's also interesting to note with regard to pharmacists that one of our Metro mayors happens to be a pharmacist and has been for many years. He stopped selling cigarettes many years ago and he told me that it made absolutely no difference to his bottom line.

The tax rollback is of concern to all of us, but it seems to me that to some degree the impact of that, not financially but the health impact, could be decreased if you were to support the private member's bill for Scarborough to have its bylaw. If that were to be extended to all of Metro, for example, then the impact of a rollback of taxes would be much lower in this area.

In that regard, it was interesting that I met with some representatives, leaders of the restaurant associations, because they are the ones who are most concerned about our bylaw and that bill preventing smoking within their restaurants. It wasn't that they didn't agree with what we were trying to do; they were concerned about the competition. They said to me that if such a ban could go right across Metro, or preferably across the province, then they would not object because they knew that there would not be competition for any of them and they would all survive very nicely, just as the airlines have in their total non-smoking, and of course cinemas for a long time.

Finally, a suggestion perhaps with regard to the sale of cigarettes: I wonder if you have ever thought of selling cigarettes in the same manner in which you sell beer and alcohol. In other words, the only place for purchasing them would be in a liquor store or a beer store, and taking it right out of everywhere else. That also would give you a better control over the age of the children coming in. It's just a suggestion that I haven't run past my staff.

**Dr Davison:** It's in the brief.

**Mrs Trimmer:** It's in the brief; okay.

**Mr Jim Wilson (Simcoe West):** Thank you very much for your presentation; it was quite good. You began by saying you hope the opposition parties support this bill. I was out in the hall talking to the cancer society. Somebody out there is running around saying that the opposition parties don't support this legislation.

I can only refer people to the second reading debate in the House and to how each party voted. Everybody voted



in favour of this bill. In fact, we're probably doing you a favour by poking some holes in it and having these hearings, because otherwise it would have won on the nod on third reading. I would ask all groups out there to consider that, that we wouldn't have the opportunity to receive all this wisdom.

Secondly, and it's more of a comment than a question, this will be landmark legislation if we see the regulations. It currently doesn't deal with plain packaging, it doesn't deal with kiddie packs and it doesn't deal with a number of things that you've suggested. So part of our role in opposition is to challenge the government to bring forward the regulations.

We're going into an election year. Anything could happen. It all sounds good in the bill, but there's no meat on the bones. In fact, it's just extending the current model, and we've been told by a number of young people that the current model, in terms of penalizing retailers and not putting any responsibility on young people, for example, just doesn't appear to be working. They tell us: "Raise the age to 19? Whippy ding-dong. It hasn't any effect on us."

We're trying to actually challenge the government. It's got a lot of credit in the media for banning kiddie packs. That's not in the bill, so I don't know what piece of legislation the media have been reporting on. It won't be in the bill until we see the regulations. We're prepared to help the government with amendments if it brings them forward.

There are a number of other things I agree with. One is the mayor's comments with respect to—obviously, where we do have a disagreement is on the pharmacy issue, because we see some of the larger pharmacies as retailers, and that's their own testimony to us, that they're both retailers and health professionals.

**1120**

It seems to me that certainly in my lifetime I can see us moving towards selling cigarettes in controlled outlets like beer and liquor stores. I can see that's the trend. I think people probably want that in the province. It would take a lot of political courage to do that, and we've been challenging the government to think about that idea too. So I appreciate your comments, your worship.

**The Chair:** Any comments?

**Mrs Trimmer:** I think we'll—

**The Chair:** Just so Hansard knows, we'll state it. We'll move then to Mr Wiseman.

**Mr Jim Wiseman (Durham West):** I think a lot of us have become aware of the need to have very strong legislation in the face of the abrogation of the federal government in its responsibilities in this area, and the fact that its actions are going to make it incredibly difficult to sustain the kinds of policies that will prevent cigarettes going down in price to where kids can afford to buy them. I am so angry about this I can hardly contain myself. As a father of kids who are just coming into that age group, I really want to have some strength and some teeth in this.

We heard a presentation yesterday in Sudbury from a school called Lively. They have a very interesting policy

where they've put together a group of students and faculty and they've discussed how they were going to ban all cigarette smoking from the school property and so on.

The one area where they were found they were running into problems was the same area that you're running into, and you need the amendment to enact your bylaw. I didn't see it in here and I'd like you to discuss this, and that is if there was some way of putting an area around the school, on public sidewalks or public roadways or public green spaces, where the kids couldn't escape to to smoke. If you ban it on the school property, I know where they're going to go. They're going to go to the sidewalk, and you sit there as a teacher or an administrator and you ring your hands and you get really frustrated. There's one comment.

The other comment is that in order to enforce this, and it was raised by a number of people, Mr Wilson and I think Ms O'Neill, and it came out of an idea, I would like to see some kind of civil action being possible on the part of parents to sue or to proceed against people who entrap young people who are under age, so that they can sue them in a civil way in order to be able to charge them. As a parent myself, I would like to have that right. Could you comment on those two things?

**Dr Colin D'Cunha:** In the area of public places, I think that could be addressed through definition in the proposed regulations when they come out. At the city level, we didn't go beyond enclosed public places because the feeling at the city level, based on advice from our legal department, was that these are matters beyond municipal jurisdiction, which is partially why it's come to you. I suspect you're looking at the environment in the broader sense, and at the end of the day I suspect you're going to end up at the federal-provincial table.

**Dr D'Cunha:** On the second point, in the area of civil action, it's certainly within provincial jurisdiction to look at some matters, and again you're going to be at the federal-provincial table, because if you're getting into acts involving the Criminal Code, the feds very much have to be involved. This is totally out of municipal jurisdiction.

**Mrs Trimmer:** On the question of the area around a school and the roads, I'm not sure that we would have the jurisdiction to deal with that in that way. I can guarantee that we'll take a good look at it, but I really don't think we would be able to do anything.

I have to wonder—I go back to the time when I was in school—what is wrong, or do the school boards or the schools themselves, the principals and the administration, not have the ability to say to all their students, "There are certain things you will not be seen doing"? For example, when I was growing up, if any students in my school were seen eating anywhere out on the streets and not in a restaurant, if we were chewing or eating anything at all, even ice cream, we were hauled up before the principal. I realize things have changed over the generations.

**Mr Wiseman:** Boy, have they ever.

**Mrs Trimmer:** However, when it comes—

**Mrs Haslam:** There are a number of teachers here. You're talking to former teachers here.

**Mrs Trimmer:** I'm a former teacher too, and I'm well aware that there is a lot of responsibility on the administration and on the teachers. I don't like situations where the buck is passed to someone else and I saw that happening when it came to selling drugs in schools. Everybody denied responsibility for being able to do something. I don't buy that. I think that collectively the schools, the teachers and the parents have to take some action themselves and to set down the rules.

**Mrs O'Neill:** I have to correct the record first. I have no recollection at all of talking about prosecution regarding this matter and parents initiating such, and Mr Wilson said he has no recollection either and he wanted me to bring that into the record, so let's get that straight.

I know that Scarborough is known across the province, indeed across the country, as being a leader in this area and I want to congratulate you. I come from the Ottawa area and my community also is looked upon as a leader in the area. I want you also to know that the Liberal members of this committee certainly feel the bill should be strengthened. We will be supporting it, but we think it should be strengthened. I'm very happy that you brought the workplace situation forward. Yesterday, in Sudbury, we had several presentations and one group actually brought forward its workplace health and safety officer. I thought that was a very good idea to make their point very clear.

What we heard more of in Sudbury—I wanted to ask you if you'd thought about it at all—was that they are really, and I think at this moment, supporting it in their community by encouragement, not monetarily, cessation programs in the workplace, cessation programs in the schools, having them as part of the credit programs in the schools and offering in the workplace that no pay will be lost; for 10 hours a week they will be permitted. I felt that was a very progressive move.

I'd like to also ask you, if this bylaw that you're suggesting, and if this bill goes forward as such, are you thinking, as a fallback position, of the municipal right to license that you have, which some other communities in the province have used. Perhaps you would like to comment on either the licensing or the cessation. Those are my questions.

**Mrs Trimmer:** I think Dr D'Cunha probably knows more about the licensing aspect.

**Dr D'Cunha:** In terms of licensing of tobacco sales, I should point out for the record that it belongs to Metro council and not to Scarborough city council or North York city council or Toronto city council, so I can't shed any wisdom from the local perspective because the power is simply not ours.

In terms of the cessation programs, as a major employer, the corporation of the City of Scarborough does offer cessation programs for its own staff, and through a process of leadership, encourages through the business community, namely, the Scarborough Chamber of Commerce, to offer similar programs. Perhaps down the road—again, this one has to go to the federal and provincial table—serious consideration should be given to tax credits to employers for instituting such programs, as distinct from taxing health benefits, which is another

proposal floating out there.

**Mrs O'Neill:** A very good idea.

**Mrs Trimmer:** One of the other concerns we have with regard to the workplace—this was brought to my attention by Dr D'Cunha—is the studies that have been done in the United States with regard to the impact upon workers in, for example, bars and restaurants who are non-smokers but are of course smokers by virtue of the second-hand smoke. There is, it seems to me, a high degree of liability for the health of those people and that has to be considered as well.

**The Chair:** Mayor Trimmer, ladies and gentlemen, we appreciate very much your taking the time to come before the committee this morning and thank you also for the copy of the bylaw which you left with us.

1130

FRANÇOIS COUTU

**The Chair:** If I could then call on our next witness, Mr François Coutu, president of Maxi Drug Stores, bienvenue au comité. Please make yourself comfortable and then go ahead with your submission.

**Mr François Coutu:** Even though English is not my mother tongue, I'll speak English. It'll give me a chance to practise anyway. I'm François Coutu. I'm a pharmacist. I represent 17 drugstores in the province of Ontario under the name of Maxi and under the name of Jean Coutu. I read Bill 119 and even though there are obviously a lot of good things in it, I can't believe we've really singled out the pharmacist as being the guilty person in this bill.

A pharmacist, as you know, is a health professional by formation, by training, but also a retailer and that's a fact of life. The pharmacist, first of all, doesn't sell tobacco products; usually they're sold at the front shop. I don't know if you have any experiences of a pharmacist selling your cigarettes. I don't believe it ever happened.

As a matter of fact, when he works at his prescription counter, he offers this community and this province a good service, a service that is provided to the public, I believe, at a cost saving to the government. I want to explain this to you by saying that mainly because he has developed a strong commercial side attached to his professional practice, this has enabled him to offer other services, to have extended hours.

For example, it's very easy, very accessible to call a pharmacist if you want to talk to him personally. He's always there to give you advice on health and everyday matters, but also, like I said, he has to compete with other people who are selling health and beauty aids or selling certain other items that he carries in his store.

One of the things that is for real is that tobacco has been a traffic-builder for a retailer. The way the bill is proposed, it's like taking all the tobacco sales that are done in pharmacies and handing them out to our competitors, with no real action on dropping or to curve down the consumption of tobacco.

For example, in our stores, we sold last year close to \$5 million worth of tobacco. With these times, I don't think I'm ready to hand it out to somebody else without having a promise that the consumption will go down. As



a matter of fact, the convenience store will probably be more than happy. They're going to look at me, "Good, now that you lost this, I'm going to have a good drive at it and sell it for you." So what's it going to bring? Nothing.

What I'm saying is that the way the bill has been proposed is actually hurting my people, my pharmacists, without even having a second opinion or a second chance of making that business that they've been losing with something else.

It also points out a discrimination issue where again I'm saying, why in this bill is the pharmacist being singled out as being the guilty person? Everybody in this room knows that tobacco is hazardous to your health. There's no question about it. I cannot even discuss it; you've heard plenty about it.

We've made a lot of progress over the years. A lot of pharmacists have taken their own decision to take tobacco out of their pharmacies and I think the trend is going further and further. As a matter of fact, in the 17 stores we have in this province, two have decided not to sell tobacco. I think it's a question of freedom of choice. If you decide that tobacco is hazardous and should be restricted, I would support restriction for everyone, not just for pharmacists but for everyone who is in the retail industry, because in this case I'm telling you the pharmacist is a retailer and is competing with other people in the same situation.

One thing that pharmacists have done, especially in our group—we have done something two years ago that it may be interesting for you to know about.

There are a couple of products we sell in our pharmacies that can help people who have had the smoking habit for a long time and cannot get rid of it. Unfortunately, we cannot advertise these products, so there are some people who are not even aware they exist.

Two years ago, we made a strong commitment with one of the companies that manufacture these products to try to see if it could make it more available to the public. A couple of years ago, and still now, to get these products—called Habitrol by Ciba and there's also Nicoderm and Nicorette which is a nicotine gum, and this one is a nicotine patch—to get a prescription for this, or at least to get this product, you have to go and see a doctor.

You're not sick; you just want to stop smoking. You have to go and see a doctor where he writes you a prescription. Obviously, this is costing something to the government. The doctor has to be paid. Contrary to the pharmacists, you go and see a doctor and he's going to get paid for it. A pharmacist, if you go and see him and ask some advice, he's not necessarily going to be paid for it, unless he sells you something. I just want to make this clear.

Anyway, you go and see a doctor and he writes you a prescription. Then he has to go to the pharmacy and fill it and that's where it goes.

We wanted to make this product more available. You don't need to go and see a doctor to get a pack of Nicorette; I don't think so. That's where I think pharmacists can help. If this product could be made available, if

the pharmacist could really help in advertising this product more and make sure that the community knows about this, I think we could help a lot of people to stop their habit.

Smoking cessation is something that is possible, and these are good products. These are a lot safer than cigarettes; you know that. As a pharmacist, I can recommend them. We've done it. For the last six months, we've tried to really work with the people we know are smokers, and believe it or not, it has worked out. Probably not all of them have stopped, you know that, but with some of them we've really worked at saying: "Listen, do you know this exists? Let's try it." Believe it or not, we've helped in stopping some of the people who had this habit for a long time.

I think in this fashion that's how pharmacists can really help.

That's my position. The way the bill is stated, I don't think it does a favour to the public. It certainly doesn't do a favour to the pharmacist because it doesn't do anything to curve down the consumption of tobacco. I wish we could bring forward some more positive way of looking at it.

**Mrs Haslam:** Are you a licensed pharmacist?

**Mr Coutu:** Yes.

**Mrs Haslam:** Obviously, you do believe in the negative effects of smoking and of cigarettes. We're trying to get towards a smoke-free Ontario. Would you be in agreement that was a good goal to be aiming for?

**Mr Coutu:** I think so, yes.

**Mrs Haslam:** Then your arguments lead to the presumption that the financial benefits of tobacco sales supersede the health goals of a tobacco-free Ontario.

**Mr Coutu:** It supersedes in one way, because you're making a judgement and it says that as a health professional I have to really take this as my priority, before my financial gain. The problem is that the way I practise pharmacy—I'm not in a clinical setting where doctors are sending their prescriptions over to downstairs and so on—I have to fight every day for my living and for this I have to advertise and I have to compete with other people.

**Mrs Haslam:** I understand that.

**Mr Coutu:** In this way, I am saying, if you take my business that I am taking now and give it to somebody else who is competing with me, I say no. You are doing me a disfavour.

**1140**

**Mrs Haslam:** I have a couple of questions and a comment. We get letters, sometimes from people can't come in and take part in the hearings. This came from a pharmacist in a pharmacy in Sarnia. I am reading it because you said you had a comment and this actually has an exact opposite comment.

"In this legislation, pharmacists are not being picked on. Rather, the legislation is recognizing both the unique role we play in promoting public health and the importance of this role in moulding public opinion. It is therefore a public health measure in the spirit and tradition of

the Pharmacy Act of 1871 and its great-grandchild, the Regulated Health Professions Act of 1994."

I wanted to ask a couple of quick questions. The Nicorettes: Are they habit-forming?

**Mr Coutu:** They are, obviously, because they have nicotine in them.

**Mrs Haslam:** Would that be one of the reasons why it requires a prescription in order to get it?

**Mr Coutu:** As a matter of fact, for the last six months it hasn't needed a prescription any more. It's under strict control by pharmacists.

**Mrs Haslam:** Why do you think the prescription is needed for the patch? I don't think of the patch as being habit-forming. Am I incorrect in that?

**Mr Coutu:** It is still habit-forming, because it does provide you with a certain dose of nicotine every day, and that's what people are driving for, having this dose of nicotine on an everyday basis.

**Mrs Haslam:** Would that be why there is a requirement for a physician to give you a prescription in order to fill those then?

**Mr Coutu:** Yes, that's what I believe, plus it should be supervised in a certain way as to how the people are taking their regimen. It's not just chewing gum; you have to have a certain fashion of doing it. As pharmacists, we have to explain how to do it to people so eventually you have this habit-forming reduced or even lose it.

**The Chair:** The parliamentary assistant on a point of clarification.

**Mr Larry O'Connor (Durham-York):** It's my understanding that the patch itself, for example, if it got into the hands of a child could in fact be lethal if it was ingested, or that even if an adult had it on their tongue, it could actually be lethal.

**Mr Coutu:** I've never heard of someone taking a patch and really swallowing it or something like that. It's been going a little further than what it is exactly. The patches have been made to steadily give a certain percentage of nicotine. It is a dangerous product. You should not have it handled by children, I understand, like any other drugs in the house. It's not a product that obviously you can have taken by children, but as an adult there's no problem using it.

**Mr Jim Wilson:** Thank you, sir, for your presentation. As you know, my party has some sympathy for the pressure this bill puts on the retail end of your business, but I have to be perfectly honest with you: With the entire broader health care sector against that argument, I don't think we're making much headway with the government on that particular provision in the bill. Unfortunately, this is a government that is not particularly interested in any retail arguments or business arguments when it comes to—

**Mr Coutu:** I know it's not very popular, because we're only a thousand pharmacists, and you've been elected by a few million people.

**Mr Jim Wilson:** Yes. You may want to start focusing your guns on a constitutional challenge, much like the home care providers are doing. I know that's probably in

process. I want to talk about Nicorettes because you mentioned that finally they're over-the-counter now. With patches, I somewhat question also whether pharmacists could do that without—when you're doing 21 milligrams of nicotine, high-end patches, somebody's heart might explode or something. They probably need a bit of a physical prior to that prescription being issued.

None the less, you did say something about you can't advertise these cessation products. I just wondered about that, because Nicorettes are certainly advertised.

**Mr Coutu:** There's advertising, but as pharmacists we cannot because it has a DIN number on it. We just cannot promote the sale of these products, by law.

**Mr Jim Wilson:** I wonder about that, because I agree with you because of the DIN number. Maybe we could help you with that, because currently you can advertise cigarettes in your front window.

**Mr Coutu:** That's what I'm saying.

**Mr Jim Wilson:** But you can't advertise this.

**Mr Coutu:** It's ridiculous; I agree with you.

**The Chair:** Thank you very much for coming before the committee this morning.

JAMES SNOWDON

**Mr James Snowdon:** Good morning. My name is Jim Snowdon. I'm the owner and manager of Snowdon Pharmacy. That's a 1,500-square-foot, full-service drugstore located in downtown Toronto. It's on the ground floor of the Medical Arts Building at St George and Bloor streets. It's not too far from where we are right now. This pharmacy has served the area for some 65 years and my family has been involved for the last 55 years: my grandfather, my father and myself.

I'm a graduate of the University of Toronto faculty of pharmacy, 1970. I'm currently a member in good standing of the Ontario College of Pharmacists, the Ontario Pharmacists' Association, the Canadian Pharmaceutical Association and I am a fellow of the American College of Apothecaries.

I'm pleased to be before the committee today to speak of my experience in the discontinuance of tobacco sales in my pharmacy and to share my personal views with you.

It has been clearly established by many others that smoking is deadly. For me, it then follows that ethically pharmacy tobacco sales are deadly.

But what was I to do? The doctors would trudge into my drugstore, plunk their money down and trudge out with their smokes. It was becoming a daily ritual at Snowdon Pharmacy and some of my staunchest cigarette buyers were physicians. But the routine bothered me. How could I, a health care professional, reconcile selling Ontario's leading cause of preventable death, and to doctors at that? I just couldn't reconcile that.

Sometimes silence is not golden; it's yellow. So in June 1989, I sold my last cigarette. I proudly did that. The consequences were that I felt 10 feet tall. I was proud as punch. I lost \$5,000 in tobacco sales a month—that's a month—and I lost an equal amount of sales in other products the smokers would have purchased with



those tobacco sales. Some 12% of my business disappeared overnight. I voluntarily gave that up for a principle.

The Canadian Pharmaceutical Association had a little bit of data at the time. They promised that the prediction would be that the money would come back in three months. Well, they were slightly wrong. The sales dollars did return in six months, but the profit dollars did return in three months. Recover we did, by selling other merchandise which had a larger gross profit. We actually gained by giving up the infamous tobacco subsidy.

We gained in several ways: We gained in dollars, we gained in customer loyalty and we gained in ease of work. We didn't have to run quite as hard to serve as many people because the items we now sold had a higher profit margin, which allowed us more time to interact with the people, which brought an upward spiral to more customer loyalty.

In this whole scenario, no one lost their job in my store. No one got penalized on their pay. The landlord received the rent on time. I paid all my bills on time. Five years later, we are still an economically viable operation without the tobacco sales, despite the fact that our neighbouring pharmacies still sell tobacco.

The big question is, will this bill make any difference to not selling tobacco in pharmacies? In the overall scheme of things, I honestly don't know. But what I do know is that smoking is contrary to good health—nobody's going to argue with that—and that change has to start in my own backyard. I started in my pharmacy and the next step is my profession. Every tub smells of the wine it holds and I want mine to smell as sweet as it can.

I'd like to acknowledge the Ontario College of Pharmacists for initiating this bill to ban tobacco sales in pharmacies and I offer OCP my complete support in the matter. I'd like to thank the Ontario government for bringing forth OCP's request in the form of Bill 119, and I support this legislation.

I'd like to thank you, the committee, for hearing me this morning in your deliberations about Bill 119. I welcome your questions and comments as time permits. I realize this is just before lunch, so I've kept it short.

**1150**

**The Chair:** That's quite all right. We thank you for coming. Just anecdotally, I can certainly remember as a young kid going with my father to the Medical Arts Building. He was a diabetic and so I realize that on many occasions we would end up in the pharmacy in the Medical Arts Building. As a kid that was always a wonderful experience to go through, to be able to go down with dad to that place, and then to go into the pharmacy where of course we always got not cigarettes but chocolate or some such good thing to eat.

*Interjection.*

**Mr Snowdon:** The soda fountain is still around.

**The Chair:** Some of us do date back, Mr Wiseman.

We have time for several questions, beginning with Mr Martin.

**Mr Tony Martin (Sault Ste Marie):** I'm sure that in arriving at your position on this issue, you also agree with the framework and the principles behind this legislation, which are to try to prevent and stop the smoking of cigarettes because of their impact on health.

I find myself this morning in a very troubling mood around the issue of what the federal government has done. Listening to your presentation, you are a person who certainly made a difficult decision at one point that had economic ramifications. We're in a position now where we've made a difficult decision in front of a challenge that we still haven't seen the full ramifications of, because as we hold strong to our sense of principle on this one, we will be impacted. The talk is already out there about an influx probably of contraband cigarettes from Quebec that we will have to deal with.

Do you have any advice for us as a government in front of that, in light of the fact that we will be criticized severely by people, as Jean Chrétien said last night, for having our head in the sand, that kind of thing?

**Mr Snowdon:** It does present you with a unique dilemma. I do not have much hope that your continued high tax will deter people from smoking in Ontario. Their sources and our borders are close enough that the tobacco is still going to run in across the borders. The tax position is not a threat to decrease tobacco consumption, and I don't think the present position is going to decrease tobacco consumption in Ontario.

**Mr Martin:** Although we're being encouraged to a person by public health groups to stay the course, what would you suggest that we might do otherwise to have the same impact that we now have with the price of tobacco?

**Mr Snowdon:** Nothing will ever be as quick as a price change. This you will not combat easily. My preference for seeing your activities directed would be to education and some changes further in legislation.

The education is well looked after in many aspects and I'm sure will be expanded. The changes in legislation I refer to are what my predecessor just mentioned, the easier availability of nicotine substitutes. We appreciate that the items he mentioned, Habitrol and Nicodette, are potentially dangerous and do need some education, but some of the roadblocks to their access need to be removed. Perhaps one of these would be the removal of the physician's visit requirement to get some of this product. There are many people with good intentions out there. Give them half a chance. They might use some of these other products, which would reduce our tobacco consumption.

I strongly support some change in the legislation as to the restriction of the nicotine intervention and support material, Habitrol and Nicorette gum.

**Mr Ron Eddy (Brant-Haldimand):** I think that's very important. Thank you for your presentation and your views on this particular matter that you've just expressed, because I think that's awfully important. Indeed, I didn't know there were the restrictions to that extent. I do know people who have used some of those products.

We've had suggestions that all sellers of tobacco

should be licensed. We've had other suggestions that tobacco products should only be sold through government outlets. There have been very few suggestions that all tobacco products should be banned, I guess for various reasons. In view of the fact that these rules or regulations are going to help somewhat, but that they're certainly not going to reduce tobacco smoking or the use of tobacco products by very much, in my opinion, what do you see as a further step that would help this situation, help eliminate or reduce even more?

**Mr Snowden:** As it stands now, it's all a negative approach, saying, "We don't want you to have this product." You haven't offered them an alternative. Going back to what we just said, you have to offer some education, which is there, but it's a very soft type of approach. Now you need to offer product, which is the nicotine substitute product, and you have to offer it freely accessible; I don't mean without charge dollar-wise, but free access to this material so that it can be consumed.

I truly feel there's a groundswell out there. Many people who smoke would like to stop smoking. It is a snowballing effect. Given half an ounce of chance, the snowball will gain in size considerably. People will move from the smoking of tobacco, the chewing of tobacco, into the nicotine substitutes, into non-smoking, and it will occur at a faster rate as the upcoming years approach. We can encourage all that with education and with the increased availability of substitutes.

I don't think you have to do any grandstand plays. I think if you stay with your tax line as it is, fully appreciating that you're not going to deter the smoking, but maintain your posture and your position and your principle by maintaining that tax line, continue with the increased education and change some other legislation rather quickly on the availability of alternative products, you will probably make a better long-term effect on the population and their smoking habits than anything else.

**Mr Eddy:** And that would reduce the beginning smokers too, the kids?

**Mr Snowden:** I think it would.

**Mr Eddy:** It would have an effect.

**Mr Snowden:** Just as a little footnote, pharmacists have been oft referred to as the least used health care professional. Here's your golden opportunity to flag them and let them do some work for you.

**The Chair:** Mr Snowden, thank you very much for coming in this morning. We appreciate it.

*The committee recessed from 1158 to 1335.*

#### BOROUGH OF EAST YORK

**The Chair:** The first witness this afternoon is from the borough of East York. Mayor Prue is here. Welcome, your worship. If you'd be good enough to introduce the members of your delegation, we have a copy of both your oral presentation as well as the written presentation. We had one of your colleagues, Mayor Trimmer, here this morning. As we move a little bit to the west, we welcome you as well.

**Mr Michael Prue:** Thank you very much. Mayor Trimmer and I are really very thankful to come here for two reasons: (1) to present what we have to say and (2)

to escape from the budget meetings at Metro council. I know that she was gone and just returned. I didn't ask her where she went, but we'll have to compare notes when I get back.

I'd like to introduce the two people with me. On my right is Dr Sheela Basrur, the medical officer of health for the borough of East York, and on my left is the chairperson of the board of health, Mr Geoff Kettel. You have my written statement. I guess I'm going to read a good portion of it, but I'm going to ad lib here and there to try to make it a little more interesting.

**Mrs Haslam:** I see you've written the ad lib part in already.

**Mr Prue:** No, no. That ad lib part was written in for me. My writing is much neater. That is a doctor's writing.

**The Chair:** That's right; it's a prescription.

**Mr Prue:** You know what they say about doctors' writing. When they scribble that note to the pharmacist saying what you're supposed to get and then the pharmacist scribbles something back, what they're really doing is saying in code, "I got mine, you get yours."

Anyway, we're very delighted to be here. On behalf of the board and the staff of the East York health unit and on behalf of the members of council for the borough of East York, we congratulate the Ontario government for taking a leadership role in this fight, and we consider it a fight, against tobacco. We applaud the opposition for taking a non-partisan supportive position on the province's number one preventable cause of death.

At a council meeting on Monday night we had an emergency resolution before us to deal with: the proposed federal government initiative to lower taxes. We didn't have much time to research it, but the council—I believe the vote was 7 to 2—voted to commend the Ontario government for any initiative or any actions that it could take to resist the reduction in the taxes. We're hearing on the news this morning that this may not be too good. You only have to see the lineups crossing the bridge into Hull to know what's happening. I think the government is in a no-win situation. But our council is on record opposing any reduction in the federal or provincial tobacco taxes and we commend the province of Ontario to do whatever you can, and it might be very difficult, to resist following the direction of the province of Quebec.

Overall, we strongly support Bill 119 for its focus on smoking prevention among youth. We believe the committee is well aware of the health benefits of supporting the bill, so we have chosen a different focus for today's presentation. Basically, what we'd like to talk about is what we think has been a very successful initiative at a local level, that is, within the borough of East York and within the East York health unit, to combat smoking, particularly among young people in the borough.

I don't have to preach to the members of the committee on tobacco. We know that it's probably the leading preventable cause of death and we as a community all know the thousand or so carcinogens found in cigarettes. What we have attempted to do over time is to convince our community of the very real dangers of environmental



tobacco smoke, the very real dangers of cigarette smoking. We've tried to do that in a way that's both fun and educational. We've tried to do it for young people, for old people. We've tried to go into public institutions. I think very much we've been successful.

A couple of the major programs: The first one's A Change of Heart. The health unit launched A Change of Heart, a community-based health promotion program modelled on large demonstration projects from around the world. We focused on three main areas: smoking, diet and exercise. We encouraged people to either quit or smoke less. We trained community dentists to counsel patients not to smoke.

Starting in the mid-1980s, true prevention began in day care centres with the smoke-free class of 2000 project. The health unit also became a pilot site for the Waterloo smoking prevention program, an initiative that focused on elementary school children. We've had several functions in the borough of East York over the last year, and to celebrate the coming into force of our bylaw, we had many children come forward. They put on plays and skits; they drew posters. They're very much involved in the whole Change of Heart program. I think we've made some significant progress among younger students, convincing them that they should never start smoking.

The tobacco-free high school project we aimed at older children, those who probably will succumb most easily to the media and to the stereotype that you see in the cigarette ads, that you see in the magazines: the cowboy riding the plains or everything else that a media genius can think of to tell people that this is somehow glamorous or sexy or important or virile or—I don't know what other words to use. We've tried through the tobacco-free high school project to show them that maybe it's—let me put it bluntly—more than a little bit of hogwash.

A 1988 survey of East York high school students found that 40% were regular or occasional smokers—I, on the board of health at that time, was really quite surprised it was that high, but it is—and that 30% of these smokers wanted to quit. Using a grant from Health and Welfare Canada, the health unit developed the tobacco-free high school project. That project conducted research, raised awareness and promoted cessation opportunities in two East York high schools. The project was unique because it was based on student-initiated activities, and we felt this was absolutely important. It wasn't some older person coming in and talking to them; it was the students themselves who initiated the activities. The health unit has since expanded the program to all East York high schools with financial support from the board of education.

Our ETS bylaw—this was a marathon session and I imagine you're going through a similar one now. This lasted four years. It took four years to come up with an environmental tobacco smoke law. We started in 1989 and we finished in 1993 and I think on May 1—

**Dr Sheela Basrur:** May 31.

**Mr Prue:** —May 31 this year it becomes law. There's a one-year phase-in period and it becomes law. It, in effect, took five whole years. The health unit started by advocating a bylaw to protect East Yorkers from ETS.

Much time and expense was incurred to obtain special legislation to enable East York to enact such a bylaw, and we'll get to that at the end. It was a very long process that we feel may and should not be necessary. Certainly East York, although we're small by Metro standards, is about the 20th-largest community in Ontario and we do have some significant resources. It would be, I think, very onerous, if not impossible, for smaller communities that want to follow our lead to go through the process of having special legislation, all the lawyers' fees that were involved and the process.

We undertook widespread consultation while the bylaw was being developed. It showed strong support for tobacco control among various communities and interest groups. In fact, our council has unanimously on three occasions endorsed the bylaw when it was addressed before us. Of all of the people who came before our council meetings or committees to speak on tobacco smoke, on ETS, I think all but one were in favour of the action we took. When I say "all but one," I'm talking about East York people or East York communities. There were of course lobbyists for the pro and con who came from far and wide to address us, but among actual East Yorkers who came forward only one came forward to speak against the ETS bylaw. He wanted permission—I forget exactly how he phrased it—to do whatever he wanted and he didn't really care whether anyone else was affected.

Since our bylaw passage, in May 1993, we've received over 200 calls from employees, employers and the public. More than 75% of the callers complain about ETS and its disabling health effects, to the point of their being unable to work, and wonder why more restrictive regulations have not been implemented and certainly are waiting for May 31.

A 1993 survey of large East York workplaces found more than 70% of employers support smoke-free workplace policies. In fact, many employers were anxiously awaiting legislation to provide them with the legal support they felt they needed to implement a smoke-free environment.

Many health agencies across Ontario, indeed across Canada, have contacted East York Health Unit to seek our assistance in developing similar programs for their communities. We believe our efforts have been extremely worthwhile for East York and may have, in the long term, benefited other communities in their fight against ETS and tobacco usage.

Overall, we commend the province for proposing a minimum standard of ETS protection across Ontario. However, we believe that stronger provincial standards would be supported by Ontario communities and we urge you to raise these standards at least to the level of our own bylaw.

We realize that we are probably in the forefront, if not near the forefront, but we think that our bylaw will, over time, be supported by the vast majority of communities in Ontario. If the committee sees fit to do so, these municipalities will not have to incur the cost of special legislation to obtain a higher standard of protection than what might otherwise happen.

We also point out that 90% of adolescent smokers will continue their addiction into adulthood if they, in fact, start and one in five of them will die from tobacco-related diseases.

In face of federal and perhaps even provincial tax rollbacks, a stronger, more effective bill is essential to protect the health of future generations. We urge you to consider our recommendations to strengthen the bill, as outlined in the attachment that we gave you.

**The Chair:** Thank you very much for coming forward and we'll get right to questions.

**Mrs Haslam:** I know our time is very limited and I know Mr Wiseman put his hand up. I think we want to ask the same question.

I'm very interested in your tobacco-free project at your high schools. You didn't indicate the success of it. I would be interested in hearing a little bit more about how that worked. I understand the idea about student-initiated activities, because many of us feel that education programs don't reach our young people, and I'd like to know how successful this one was, given that you took a different tack.

**Mr Prue:** I'll turn this over to Dr Basrur who, I'm sure, can answer these technical questions.

**Dr Basrur:** Okay. The program has evolved somewhat over the years, so I'll just try to speak as briefly as I can to it and say that the tobacco-free project was almost a community development project within the high schools. There were some test high schools that we used and we worked through the student councils, the principals, the parents, what we would call the school community, to identify what they would like to have happen in the area of tobacco control and tobacco use prevention.

So the way in which it unfolded was really a reflection of the school community. In some cases it took the form of contests or challenges. It may have taken the form of assemblies and skits and songs and videos and all kinds of creative things that these kids come up with aimed at promoting a tobacco-free environment or getting kids to quit or not to start because it wasn't cool or it wasn't smart, that type of thing. That was the main thrust.

**Mrs Haslam:** I meant, you had a 1988 survey that found 40% were regular or occasional smokers. Was there an additional survey following these activities that showed the activities worked?

**Dr Basrur:** We are planning a survey to do exactly what you're describing, take a look and see if there is a downward trend. That survey's still in the planning stages.

**Mr Wiseman:** Yesterday we heard from two young people in Sudbury who had a similar project at Lively high school. The question I asked them was, were they then thinking about taking the peer groups—the young people who had started to smoke, became addicted to smoking, wanted to quit—into the elementary school, because some kids are starting as early as grade 6, 7 and 8 now, to talk about the negatives of being cool and trying to push that peer pressure down further so that they can have an impact at an earlier age?

**Dr Basrur:** It's an excellent idea. I'm not sure if it

has actually been used in East York. It may well have been considered because we have focused in the past on role modelling for kids using their own peers, not to have parents try to describe a role model but to bring people that they can relate to, and certainly high school kids talking to elementary would be a terrific idea. It may or may not have been used; I don't know.

1350

**Mrs Cunningham:** Thank you very much. It's a pleasure to see such leadership in the municipalities and some of the work that you've done. The research that you've done in East York I think is going to be very helpful, not only to us but to other school boards and municipalities, I'm sure.

I did read the additional submission, Dr Basrur. The medical officers of health, by the way, have been quite outspoken, at least as I long as I've been around, and it's about time, because it's that kind of leadership. So I'm complimenting you. You've helped some colleagues.

You talk about the bill being strengthened, that the regulation of tobacco retailers be actively enforced. There are more fines, but I was really thrilled to see you go so far as to say—I think you did in here; I read it quickly—that they be licensed to sell tobacco. I wondered if you would go further. One of your colleagues suggested that cigarettes ought to be sold along with liquor products in LCBO outlets, so if you would respond to that.

Also, you're aware that although we talk about plain packaging and the abolition of these kiddie packs, it doesn't appear anywhere in this legislation, something that everybody's talking about. Would you say it should be legislated or regulated? If you can respond to those two issues, I'd appreciate you elaborating on your own paper in that regard.

**Dr Basrur:** From my point of view, from a public health standpoint, tobacco is a hazardous product. I believe one of the other issues is whether it should be designated as such legally under federal legislation, and I would certainly support that. When one thinks of what tobacco contains and what it does, there's no reason why you would exempt it.

Having said that, again it makes sense to have very strict controls on the retail. Intuitively one might say that you either sell it in liquor control board outlets or you have a tobacco-control-board type of system. The question then becomes, if you do that, is the community ready to accept that or not? I think it's a gradual thing that needs to be in place or you might wind up with an unenforceable law, as we have seen the consequences of, and you might have a back-and-forthing that is ultimately not helpful. But I would certainly say that's the way to go.

It becomes unfair eventually on the retailers who are just trying to make a living. They've got a legal product; they're trying to sell it. There are more and more controls. Why not just take the issue out of their hands and sell it the way it ought to be sold, which is with very strict controls?

**Mrs Cunningham:** What about the packaging?

**Dr Basrur:** The plain packaging?

**Mrs Cunningham:** And the kiddie packs.



**Dr Basrur:** Kiddie packs, for sure, are aimed I think at people who are unable to afford the full price of a pack, whatever that happens to be today.

**Mr Wiseman:** Right now a full pack is less than a kiddie pack.

**Dr Basrur:** Yes, exactly. In principle, kiddie packs ought to be outlawed. Whether they can be under provincial legislation or whether it would require federal, which they've said they will do, of course that should be in place. The plain packaging, absolutely. Again it's a matter of whether society is ready to accept the fact that they are really buying the packaging; they're not so much buying what's in them.

**Mrs Cunningham:** Thank you for your leadership, all of you.

**The Chair:** Mayor Prue, on behalf of the committee, thank you and your colleagues for coming before the committee and for your presentation. We appreciate it.

#### ONTARIO COLLEGE OF PHARMACISTS

**The Chair:** I next call the representatives from the Ontario College of Pharmacists. Welcome. I know you're not strangers to this forum. Please go ahead.

**Ms Midge Monaghan:** Thank you very much. My name is Midge Monaghan and I'm the president of the Ontario College of Pharmacists. I'm accompanied today by the registrar of the college, Mr Jim Dunsdon. We have a copy of our presentation for you, and I'm looking forward to your questions at the completion of our presentation.

As the official representatives of the Ontario College of Pharmacists, we appreciate this opportunity to make the following submission to the standing committee on social development respecting Bill 119, the Tobacco Control Act, 1993. We also compliment the committee on the work that it is doing and the time it is taking to hear submissions on this very important matter.

The practice of pharmacy is included in the list of health professions regulated by the Regulated Health Professions Act, and the Ontario College of Pharmacists is its governing body. Established in 1871, the college mission is to contribute to the health and wellbeing of the public of Ontario by ensuring that pharmacists provide optimal pharmaceutical care. In carrying out its objects, the college has an overall duty to serve and protect the public interest. While the college council consists of, in the majority, pharmacists elected by their peers, the college does not represent the mercantile interests of pharmacy.

To let you know how our college is structured, I wanted you to be aware of the fact that we have 23 members on our college council. Fifteen members are elected from community practice across Ontario. We're divided into 15 districts throughout the province. We have one hospital representative, we have the dean of the faculty of pharmacy, University of Toronto, and we have six lay representatives, who are appointed by the Lieutenant Governor of this government. Whether these members are elected or appointed, their role is all the same. We are here to advance the objects of the college.

The college's mandate includes the responsibility for

licensing and regulating pharmacists in Ontario, for the accreditation of pharmacies in compliance with operational standards and for the regulation of the distribution and sale of drugs to the public. There are currently about 8,230 pharmacists in the college register and 2,330 accredited pharmacies.

Although it possesses significant pharmacological properties, tobacco has historically been considered a recreational substance and has been freely sold in both pharmacy and non-pharmacy outlets in the province. The adverse effects on human health of the use of tobacco are well documented, and the contentious issue of the appropriateness of the sale of tobacco in pharmacies, which are facilities providing health care services to the public, has been discussed by college council for many years.

I want to emphasize that the college's position that tobacco products be eliminated from pharmacies has been consistent since October 1990, spanning two council elections, and most recently reaffirmed in June 1993. All members of council, whether appointed or elected, share a common public-interest responsibility and any policy decision established by the college must reflect this responsibility, not the economic interests of its members.

At this point I'm going to ask the registrar to give some background on what's happened since then.

**Mr James Dunsdon:** Thank you very much. I'd like to just highlight a few things leading up to the introduction of the bill and to say first that the college's formal consideration of tobacco does go back about 15 years. There was concern about the hazards of tobacco use at that time and the council of the day did pass a policy urging those members who chose to sell tobacco products to post cautionary warnings which complemented those warnings that were on the tobacco packages at that time and as approved by Health and Welfare Canada. The posting of these warnings occur in the pharmacy premises. That was the first formal action that the college took with respect to this matter generally. That was in the early 1980s.

Then as the 1980s advanced, the Canadian Pharmaceutical Association developed a program urging its members to voluntarily cease the sale of tobacco products. This was supported by the Ontario Pharmacists' Association, and the college at that time supported these voluntary efforts. We also encouraged pharmacists to educate their patrons on the hazards of tobacco use at that time. These voluntary initiatives did result in some pharmacies removing tobacco products, but a large majority continued to offer tobacco for sale.

Then in June 1989, council adopted a policy of disapproval of the sale of tobacco products in pharmacies. At that time the college acknowledged that it had no legal authority to prohibit tobacco sale and indicated that the policy of disapproval was circulated as guidance to pharmacists who did have the legal right to make their own decision on the matter. At that time, council indicated that it would review its ongoing policy on this matter.

The result of this policy of disapproval saw a few more pharmacies remove tobacco, but it became clear that

the voluntary approach had reached a high watermark, so to speak, with only a few additional pharmacies making the decision voluntarily, the rest continuing to offer the product for sale. As a result of this and also including various representations at the time from interested parties, including such agencies as the cancer society and other anti-smoking groups, the council, at its October 1990 meeting, adopted the following motion:

"Whereas it is the intention of this council to work towards the elimination of tobacco sales in pharmacies as quickly as it is practical to do so, be it resolved that a special task force be established by the president, such task force to present to council ways to accomplish this objective, and that the final report be presented to council at the April 1991 meeting."

#### 1400

This was approved, as mentioned, and a task force was accordingly struck with the following terms of reference:

"To assist council in reaching the goal of eliminating tobacco sales in pharmacies by:

"(1) Seeking the views of interested parties on issues and conditions in pharmacy practice relevant to the process of eliminating tobacco sales in pharmacies;

"(2) Identifying the components of an action plan to achieve the goal of the elimination of tobacco sales in pharmacies;

"(3) Identifying opportunities for individuals and groups, both within and outside the profession, to work towards the broader goal of the elimination of tobacco use by society; and

"(4) Reporting its findings and a course of action to the college council in April 1991."

The task force commenced its work, calling for submissions from interested parties, and it certainly did generate a fair amount of interest. We had I think just over 200 submissions to that task force. The final report of the task force was presented to college council in June 1991, rather than in April, largely because of the interest generated by this particular matter.

This report will be provided to you. It notes here it was appended to the submission. It's not appended to the submission, but we will provide the full report to you. In the meantime, I would like to just highlight certain aspects of the report, if I might.

The report incidentally was approved after discussion, with one minor amendment dealing with guidance to pharmacists respecting the reduction of tobacco promotion in their pharmacies. We set up some guidelines that were not requirements, but there was a minor amendment to the time line on that. Otherwise, the report was approved. The recommendations in the report included:

—That the college request the Minister of Health to table in the Legislature enabling legislation which would ban the sale of tobacco products in accredited pharmacies in Ontario with a commencement date of July 1, 1993. There was a two-year-to-commencement date recommended at that time.

This was the key recommendation in the report. It followed an examination of various legal options avail-

able to us. They included the concept of including a specific reference to the matter in our code of ethics, or establishing a ban through professional misconduct regulations affecting members. These were possible approaches, but the legal advice at the time drove the task force to recommend and indeed the council to agree that legislation banning tobacco from pharmacy premises was the best approach.

—That the legislation to be drafted be a cooperative effort between the college and the Ministry of Health.

—That, for the guidance of members, a recommended schedule of activities—I alluded to that before and that's where the amendment came—aimed at the progressive reduction of tobacco promotion in pharmacy premises be published. These activities would include the placing of tobacco products behind service counters, the elimination of back-bar displays and all activities respecting the advertising and promotion of tobacco, locating tobacco products below the level of service counters and removing products from public view in a phased reduction or promotion.

—Another recommendation contemplated the development of educational programs in cooperation with the Ministry of Health, utilizing pharmacists and aimed at the prevention of smoking, including the development of suitable materials and encouraging pharmacists to support and become involved in community programs aimed at the provision of appropriate information on the hazards of smoking.

Finally, a suggestion that the college urge the Minister of Health to examine the feasibility of establishing a controlled system of tobacco distribution, using as a model the sale of beer and liquor.

This report was sent to the Minister of Health shortly after its adoption. The Health ministry acknowledged receipt of it in August 1991 and pointed out to us that a comprehensive province-wide tobacco control strategy was being developed.

With respect to government proposals, you are all aware of the Minister of Health tabling, in January 1993, a discussion paper on tobacco which identified the health issue respecting tobacco and set out a proposed strategy, including legislative initiatives. These proposals had particular focus on smoking in adolescence and included the following statement:

"As it is contradictory for health professionals who restore and promote good health to sell tobacco products that are harmful to health, we propose to prohibit the sale of tobacco products in health facilities and prohibit the selling of tobacco products in pharmacies."

The Ontario College of Pharmacists, in commenting on the discussion paper, affirmed its policy position respecting the elimination of tobacco products in pharmacies, reiterated its view that a commencement date for enabling legislation should be in place, and expressed support for the idea that premises which contained a pharmacy should be free of the sale of tobacco. Subsequently, Bill 119 was then given first reading as a government bill on November 22, 1993. I would ask Ms Monaghan to conclude.



**Ms Monaghan:** The college commends the introduction of this proposed legislation and supports the provision of Bill 119. Noting that the bill contains a number of provisions relating to such matters as packaging, warning, vending machines and controls relating to smoking, our comments will be focused on the matter of prohibition of sale in designated places, as set out in section 4. The college concurs with the inclusion of pharmacies as designated places for the purpose of the bill. Pharmacies operate in a retail environment and many, but not all, include a wide variety of goods in their premises. However, unlike other retailers, they also provide prescription and non-prescription drugs to the public.

While accredited pharmacies are established in a variety of community settings, it is our position that all pharmacies provide an essential health care service to the public and, accordingly, meet the definition of a health care facility. We note that included in the definition of a designated place is a retail establishment if "a pharmacy is located within the establishment, or customers of the pharmacy can pass into the establishment directly or by the use of a corridor or area used exclusively to connect the pharmacy with the establishment." We are pleased to see this definition as it results in an equitable treatment between such establishments referred to as "non-traditional pharmacies" and the pharmacies that "stand alone."

We also note, and agree with, the one-year commencement period set out in subsection 4(3) of the bill to enable pharmacy owners to have the opportunity to comply with the provisions of the legislation.

In conclusion, the college is aware of the controversy surrounding the issue of tobacco sales in pharmacies. This has been a difficult issue for the profession as well as for the college. Self-regulation is not always easy, and the speculation you have heard about our election results reveals some misunderstanding about the objects of professional regulation, as illustrated by the Regulated Health Professions Act, of which pharmacy is a part.

While all pharmacists, in our experience, appreciate the health hazards associated with tobacco use, there are differences respecting how to deal with tobacco sales. For its part, the Ontario College of Pharmacists is convinced that the sale of tobacco in pharmacies, health care facilities, is simply incompatible with the role of the pharmacist as a professional providing health care to the public. This is the reason for the college's policy on this matter, and this is the reason why we support Bill 119.

1410

**Mr O'Connor:** Thank you for coming. It certainly will be useful. I ask the clerk to pass this to you because it's part of what I wanted to ask you about.

We've heard many different views about where the college is at one this issue, so we certainly appreciate you coming and helping us out on this. The picture of a pharmacy that's going to be shown to you is actually one that was presented to us while we were up in Sudbury. You'll see in the picture it's got the du Maurier advertisement, which of course is for their jazz festival. I guess it's impacted by the federal legislation, Bill C-51, which has been tied up in the courts going through part of the

problems. Just so that maybe you can help, because we've heard from people who are very disheartened that this type of advertising does take place, though it's not advertising; it's promotional and it's sponsorship. It looks like advertising to me, but it's not advertising.

Would you then, from the college—I'm king of putting you on the spot here—say that it is most likely inappropriate that this type of sponsorship advertising does take place? It doesn't deal with our legislation, but we're certainly going to hear from people because people have been coming to us saying that this is advertising. You can see by the sponsorship ad here that it's the package and the colours of the package that relate to the advertising that takes place.

**Ms Monaghan:** I share your concerns; I do. Perhaps I'll ask the registrar to respond to this particular issue.

**Mr Dunsdon:** We alluded to this in the task force report by way of the guidances. The college does not have legislative authority, yet I think it's clear from the task force report, the thrust of that report, which was to diminish and then eliminate any kind of promotion over time. It was the report's attempt to be helpful with respect to this, realizing that pharmacies which were selling tobacco products did need some time to get out of that particular area. Certainly this—it's more than subliminal, I guess it goes beyond that—is in that particular category of promotion and advertising. That sort of thing would be an example of the sort of promotion that the college would see diminishing and then finally being eliminated.

**Mr O'Connor:** That's why we get people coming to us suggesting we go to plain packaging.

**Mrs Cunningham:** I'm noting in your task force report of June 1991 that you suggested "that the college urge the Minister of Health to examine the feasibility of establishing a controlled system of tobacco distribution, using as a model the sale of beer and liquor," and others, including medical officers of health, have also brought that to the attention of the government.

I'm assuming you worked on this legislation with the government because you offered that support in the task force report. Were there any discussions around this model or was there any new information gleaned from your recommendation? Did anybody do anything about it? It's been around for two and a half years, I think.

**Mr Dunsdon:** Yes, there was some discussion between the college and the ministry with respect to legislation, and some issues were identified as a result of that, among which was this concept. As I recall, the Minister of Health at the time, I believe it was Minister Lankin, did in fact raise the matter of a control system prior to the release of the strategy in 1993.

I can't recall exactly how prior it was, but it was sort of floated as a possible thought, and it did not receive a very enthusiastic reception, as I recall, notwithstanding that there was some certainly informal discussion around this particular concept, and as mentioned in our brief, it was an idea that certainly the college felt was worth pursuing.

**Mrs Cunningham:** How do you feel about licensing

retail distributors?

**Mr Dunsdon:** Could you just expand a little bit?

**Mrs Cunningham:** Right now, as you know, we have a system in place, and there are fines. This legislation increases the age and also makes the fines greater. Since no one is enforcing the legislation and hasn't done so, one has to wonder what difference this would make. I'm an optimist, so I hope it'll make a big difference.

*Interjection.*

**Mrs Cunningham:** Huge fines, all right? So there's going to have to be a system of enforcement in place, there's no doubt, for this to work.

Some members of the public have come before the committee and said, "If we're going to get into the controversy," like you've had in your own profession, "why doesn't the government take the lead and say, 'If you want to sell tobacco, you get a license,'" and there would be certain requirements to get the license? But more importantly, if you're caught selling it to people under age, you lose your license, maybe after one warning or something.

Now, we've been told that this is a cumbersome system and that's why the government didn't put it forward in the legislation. But I wonder, because if you're going to take the stand you took, which I think is a step further than licensing—when you say it wasn't met with support, I have to wonder who it was sent to. You can tell me who it was sent to. I know the retailers wouldn't like it, but I'm in the business of not having kids smoke. That's my job.

**Mr Dunsdon:** When I made that comment, I think it was with respect to the public reaction that resulted as a result of that idea being advanced. But as far as licensing is concerned, I guess one could say that's in effect an offshoot of the big license that the tobacco control board concept would result in, and to that extent it's certainly not in conflict with the college position.

I guess I'm struggling a bit because we did not specifically discuss at any length the idea of a license as distinct from a tobacco control board concept, which I guess you could describe as one big license.

**Mrs Cunningham:** That one would certainly meet your approval probably a little better, because you'd get rid of your own controversy within your group. It would be helpful.

**Mrs Haslam:** I'm glad we do have some extra time to question you.

We get some letters, even though people can't come in to the committee. This one in particular I found very interesting. It is from a Vernon K. Chiles from the Sarnia Pharmacy. I read a bit of it this morning: "The legislation is recognizing both the unique role we play in promoting public health and the importance of this role in moulding public opinion." He was talking as a pharmacist.

I found another part of the letter very interesting, given what you were saying, and I'd like you to comment on two aspects of what I'm going to read.

"A Minister of Health in the previous government recognized the need to get tobacco out of pharmacies

when she provocatively suggested in a speech to the Ontario Pharmacists' Association in 1990 that it might not be appropriate to pay pharmacies that sold tobacco for drug benefit prescriptions. The present legislation is a more comprehensive approach and reflects the fact that, since 1990, the Ontario College of Pharmacists has asked for legislation to eliminate tobacco from pharmacies."

The first part you may or may not wish to comment on; it was an interesting idea, and I really don't know who said it. I don't know if it was my colleague or not.

The part I found very interesting is that we've had people come before us and say, "The board was overturned because of the stand it took." Yet I see that it has been consistent in its message, and I would like you to comment on what one of the people had said about that. Plus, one of the comments from an individual who came before us was that if the vote was taken today, he didn't believe it would be the same vote.

You're the college; you're here to answer those things. I couldn't say he was not in a correct mode when he was talking about that, but I'm looking for you to clarify those positions, if you could.

**Ms Monaghan:** Well, it's interesting from our point of view, and perhaps embarrassing also, to have these kinds of comments coming from our council members. Truly, we have to look at these comments as being speculation on their part. Perhaps their perception is that that would happen. But as you see, we have addressed the issue at least three times, and we have consistently shown that the college council continues to support our policy of October 1990. There is no question in my mind that that is the fact.

Now, as far as doing it again today is concerned, who's to say? I can't believe there is that ability to speculate and pretend that it could be different.

**Mrs Haslam:** That was the clarification I needed.

**The Chair:** Mrs Caplan, final question.

1420

**Mrs Caplan:** I'd like to congratulate the college for the position that it has taken. I remember in the spring of 1989, when as Minister of Health I spoke to the Ontario Pharmacists' Association and asked the question of the profession at that forum, "Do you think drugstores should sell cigarettes?" there was a lot of discomfort as well as some applause. So I know that the profession is mixed in its views and I think it's come a long way under the leadership of the college.

We know that a lot of pharmacists, particularly independents, have voluntarily stopped selling tobacco products. We also know that there are some pharmacists who, while technically they have to own the pharmacy, are in a partnership relationship with one of the large tobacco manufacturing companies and I think feel some pressure about where their economic interest lies on the issue.

Have you, in the response from members of the profession you've heard from, had any sense that the attitudes are changing and that more and more pharmacists feel that they are health professionals and are supportive of the council's position to ban the sale of



tobacco products in pharmacies?

**Ms Monaghan:** I don't know. Maybe I'll ask Jim to report on any numbers we may have on that.

**Mrs Caplan:** I saw a figure somewhere that said about 37% or 38%, almost 40%, were supportive of the ban, while some 60% were opposed. I get the sense that attitudes are changing. Perhaps these hearings are helping. I'm just wondering what you're hearing.

**Mr Dunsdon:** I guess we're hearing the same sorts of reports. I don't know that there's any definitive answer. It's such a dynamic situation and I know of no definitive study on the attitude. We would like to think certainly that attitudes have changed and are changing with respect to this, and unhappily, perhaps, there's really no way to really quantify it with precision.

**Mrs Caplan:** Someone suggested to me that it shouldn't just be a matter of economic interest but as a health profession; not only pharmacy but all the other health professions should consider it a professional obligation. It was put that perhaps there should be an amendment to the act that says it would be considered professional misconduct for any health professional to sell tobacco products. How do you feel about that?

**Mr Dunsdon:** It's certainly noteworthy that I can't think of any health professional who does in fact sell tobacco products.

**Mrs Caplan:** Right now there's nothing stopping a health professional from owning a tobacco kiosk.

**Mr Dunsdon:** True, there isn't, and the professional misconduct route was discussed. It was felt, though, that on the basis of our best legal advice the banning of the thing from the place was the better route.

**Mrs Caplan:** Thank you. I appreciate that.

**The Chair:** Thank you for coming before the committee today and for your statement. We appreciate it.

DAVID HETHERINGTON

**Mr David Hetherington:** I'm very pleased to have been given this opportunity to present my personal views to you today regarding Bill 119.

My name is David Hetherington and I have been a licensed pharmacist in the province of Ontario for almost 20 years. I held the position, or rather I held several positions of increasing responsibility in hospital pharmacy for the first half of my career, and I have worked in the retail pharmacy environment for the past nine years.

For the past six years I have been a regional manager for a large pharmacy chain, Pharma Plus Drugmarts. In this position my responsibility is essentially to oversee and direct the operation of 20 retail drugstores, including both the front shop and pharmacy operations within each store.

As indicated previously, I am here today to provide you with my own personal opinions and viewpoint, although I will briefly draw upon my recent work experience in the trenches to emphasize several key points.

In general, as a health care professional and non-smoker, and I must say I have never smoked, will never smoke and am generally anti-smoking in philosophy, I

wholeheartedly support the overall intent of Bill 119, this being to discourage smoking in our youth by restricting and controlling the acquisition of tobacco products, with the ultimate goal being to reduce the incidence of smoking in our society. The legislation is indeed a beginning.

However, I am very concerned about and strongly oppose the specific section of the bill which proposes the banning of tobacco sales from drugstores. My reasons for opposing this provision, and I'm sure most of these you've heard already, are as follows:

This ban will have no impact, in my opinion, on reducing the availability of tobacco products. The public will indeed quickly and easily find alternative sources. Hence, ultimately nothing will be achieved in the quest to reduce smoking and its related morbidity and mortality. If anything, the proposed ban will further divert legitimate sales into the very extensive black market, which is certainly a more affordable alternative.

Furthermore, pharmacies are undoubtedly one of the most vigilant retailers when it comes to prohibiting tobacco sales to minors. As a regional manager I periodically audit stores to ensure that required signage is posted and that staff are complying with the law. Is this likely occurring in convenience stores, restaurants and gas bars? I doubt it.

As tobacco is a legal product, I believe this proposed legislation is unfair, arbitrary and discriminatory against our segment of the retail industry. Unless you are willing to severely restrict, license and control the sale of tobacco as with alcohol, then retail pharmacies should not be disadvantaged to this degree.

While the topic of the economic ramifications of removing tobacco from drugstores stirs up great debate, my belief and indeed my experience are that such a ban will create significant economic hardship. When combined with the impact of the social contract and other potential professional fee-limiting legislation such as Bill 81, this ban truly will diminish the viability of retail pharmacy in Ontario and result in job loss.

For your information, in my region over the past two years tobacco sales and gross margin dollars have declined by just under 50%. Overall margin rates and profit levels have been salvaged in many stores only with very significant expense control, which includes man-hour reductions in most stores. Total removal of tobacco sales and the loss of companion sales would definitely result in further reduction in man-hours, therefore job losses, and I would suggest that in my region of 20 stores at least two stores that employ 18 people in total would close, as this move would push them over the brink.

Additional economic consequences would occur even if tobacco sales are replaced by sales in other categories of front-store merchandise in that these sales may be very low-margin promotional sales, and many stores have leases which are tied into percentage rent. In this arrangement, once a threshold of sales is reached, percentage rent kicks in, such that the rent based on the incremental non-tobacco sales may be four to five times higher than that based on the previous tobacco sales. Reduced profitability and its consequences are clearly to occur while again no public health gains are achieved.

The reality of pharmaceutical care in this province is that it exists and is provided by health professionals within a very competitive retail environment. We are indeed both health care professionals and retailers. Each component, each end of our stores, supports the other to varying degrees. Most stores require both in order to be economically viable. Hence, a move such as the banning of tobacco sales will significantly alter this balance. Indeed, certain layoffs and store closures will reduce the availability of valuable and free health care advice to your constituents and the people of Ontario.

While it has been argued that the sale of tobacco in pharmacies is paradoxical and conflicting, I do not see it that way. It would be conflicting if pharmacists actively promoted and encouraged tobacco use. However, reality again is that pharmacists do not promote tobacco use but rather actively promote over-the-counter smoking cessation products such as nicotine gum, and dispense and counsel patients on products such as the nicotine patches. I would suggest that the true health care value which the public of Ontario receives in pharmacies is derived from the quality and availability of the services and information which the pharmacists provide, rather than simply the nature of the products carried on the front-store shelves.

My recommendation to you, therefore, is to amend the proposed legislation to remove drugstores from the list of prohibited vendors of tobacco products. Allow retail pharmacies to retain the ability to decide whether they will continue to sell tobacco products or whether they will voluntarily remove tobacco from their stores. In this free and democratic society, let the public decide if they will continue to frequent pharmacies which sell tobacco products.

**1430**

This is a complex issue, made even more so by our federal government only 48 hours ago. I urge you to follow their lead. In particular, I applaud their punitive focus, their public health education focus and their efforts to redirect tobacco sales back into the legitimate, better-controlled marketplace which includes retail pharmacies.

In conclusion, I again urge you to reconsider Bill 119. Make the necessary amendments so that it is a more rational piece of legislation, one which is more equitable and palatable to the majority of retail pharmacists in this province, pharmacists who wish to retain the ability to decide if they will continue to sell this legal product. Thank you.

**The Vice-Chair (Mr Ron Eddy):** Thank you. Questions? Mr Dadamo.

**Mr Dadamo:** You honestly don't see a conflict between on one hand giving medicine that makes people feel better and on the other hand selling a product that will ultimately kill you?

**Mr Hetherington:** As I indicated, no. Clearly, in an idealistic setting one arguably could agree. However, the consequences of that in Ontario, in Canada, in the marketplace that we trade, are such that certainly through this legislation nothing will be gained, and essentially in the bigger picture the availability of health care of the

professional pharmacist's advice may in fact be reduced by legislation such as you're proposing.

Clearly I stated up front, and most pharmacists would agree, that tobacco is a significant health care risk. Then go the full step. Don't just stop where you're at today and put us in a disadvantaged position, but go all the way to license or further regulate the product. Then we probably wouldn't have this debate. The issue is that you're putting retail pharmacy at a great disadvantage relative to the rest of the marketplace. That's the reality of the world we're in today.

**Mr Dadamo:** The reality is, I guess if we cut through everything we figure out that the bottom line is the most important thing, is it?

**Mr Hetherington:** Bottom-line profits?

**Mr Dadamo:** Yes.

**Mr Hetherington:** I wouldn't say it's the most important thing. Obviously there are many pharmacies that marginally make money but exist to provide a service. The company I work for would be, I suppose, included in that group, but without profits obviously one can't operate. If we were in a different world, in perhaps a European setting where pharmacies are a quite different entity, a very professional apothecary, then clearly it would be a different playing field. But again the reality of the Canadian marketplace is that pharmacy, provided to the public, is in a very competitive retail environment.

**Mr Dadamo:** There have been pharmacists who have come here and said, whether they have one store or many, that the bottom line is not that important. In other words, if they took away the tobacco products, they wouldn't see such a significantly drastic profit—

**Mr Hetherington:** Again, I'm sure you've heard the arguments that pharmacies are a very dynamic and rather heterogeneous mix of stores. I would again agree that some rely very little on their tobacco sales while others rely to a significant extent on tobacco—to the extent, for example, in my region some stores 2% to 3% of their sales are tobacco. The loss of tobacco sales in those quite honestly would be insignificant. However, where sales are 12% to 15%, that could be a significant factor.

**Mr Dadamo:** Yes. Okay. Thank you very much.

#### ONTARIO COLLEGE OF FAMILY PHYSICIANS

**Dr Brian Morris:** I'm Dr Brian Morris, an Ontario family physician. I'm here as spokesman for the Ontario College of Family Physicians. With me is Ms Cheryl Katz, who is the executive director of our college.

We are here to speak on behalf of the Ontario College of Family Physicians, which is a voluntary body of almost 5,000 members. We represent family physicians from Toronto, London, Sudbury, Thunder Bay, Burk's Falls, Iroquois Falls, Smoothwater falls, every other falls in Ontario. We likely represent your family physicians.

As family physicians, and as members of the Ontario College of Family Physicians, we have a mission statement, and I'll draw the committee's attention to two items on that mission statement: that we promote high standards of care in family practice and we contribute to public understanding of healthful living. It's on that last point that I wish to speak to you today.



We care about Bill 119 because we care about the health of our patients. We care because we see on a daily basis the results of tobacco addiction. We see the scrawny premature babies born to the teenage smoking woman. We see the elderly emphysemic huffing and puffing to walk across the room. We see the 35-year-old who has just had his first heart attack. We see the teenage asthmatic who's losing more and more time from school because of her smoking habit. We see teenagers continuing to get addicted, 3,000 new teenagers a month, I have heard. Indeed, 90% of smokers start before they are 20. These are children who are starting to smoke. Among 15-year-old boys in Ontario, 22% are regular or occasional users of tobacco. Among girls, 29% are regular or occasional users of tobacco. These are horrifying numbers. This is why we are here: because we, as your family physicians, see these things happening and we want it to stop.

What do we want? We want a smoke-free society. Coming in here to this committee hearing, I walked up the front steps of the Parliament buildings, coughing my way through a cloud of smoke on the front steps of this building coming in to address this committee.

**Mr Dadamo:** It hovers around here all the time.

**Dr Morris:** Thank you; I'm glad to hear that. That's why I live up in Barrie. We want a smoke-free generation. My daughters are young teenagers. I want them to grow up with smoke-free friends, smoke-free partners.

Specifically, what do we want? We want Bill 119 passed, with an early implementation date.

Among the specific features in Bill 119 that we would applaud this government for bringing forth is the ban on sales in pharmacies. I respectfully disagree with the previous speaker. They are health professionals. Buying cigarettes in a pharmacy is implicitly hearing that it's okay. We couldn't disagree more strongly. The sale of tobacco in pharmacies must stop.

We strongly applaud the move to increase the legal age for purchase of tobacco to 19. This is crucial. This gives these teenagers one more year to mature, one more year to understand our message about smoking, one more year to grow up without tobacco.

We strongly applaud the move to outlaw the use of tobacco vending machines. Children can buy cigarettes from vending machines very easily. Reducing access to cigarettes works. In every jurisdiction in which it's been done, reducing access to cigarettes works to reduce the number of smokers.

So those specific parts of Bill 119 we strongly approve of. We like all of Bill 119, but we want more and we would respectfully request that this committee consider some specific amendments:

First, an amendment that would outlaw kiddie packs, these being packs of five or 10 cigarettes that are more affordable for young teenagers, and require plain packaging. Buying your cigarettes in a dirty-brown paper wrapper about the colour of emphysematous lungs would be good, with the name of the company in small print on the bottom and the rest of the package filled with detailed health warnings. This would have a dramatic impact. It

would also remove the implicit advertising. Every time somebody across the room pulls out one of those bright-red packs, you know they're a du Maurier smoker. Every time they pull out one of those blue packs with the nice navy blue on it, you know that's a Player's smoker. That is tobacco advertising that happens on a daily basis in Ontario. That is worth millions to these tobacco companies and they spend millions promoting their colours. Plain packages would remove that. We know it works for them; plain packs would work for us.

The next specific recommendation we would make is for more detailed health warnings with even more power to them. The Ontario warnings are good; let's make them tougher: "Cigarettes kill people." "Cigarettes will kill you if you continue to smoke." Let's get blunt about this.

#### 1440

Our next specific recommendation is tougher regulations with regard to environmental tobacco smoke. Asbestos is a cancer-causing chemical. It's a carcinogen. If a school is found to contain asbestos wrapped around some insulation in the ceiling, the school is evacuated. Crews in spacesuits go in to remove that asbestos. But we expose children to environmental tobacco smoke in restaurants and all kinds of other public places. This is a class A carcinogen, according to the Environmental Protection Agency in the States. Class A, the strongest type of cancer-causing chemical, and yet our children and the rest of us are exposed to this cancer-causing chemical involuntarily if we want to go out in public. Let's tighten the regulations on environmental tobacco smoke in the workplace and in public places.

Finally, we would respectfully request a system of licensing retailers. The LCBO is a licensed outfit that sells a potentially dangerous chemical. Let's get at least as tough a licensing system to license the sale of this fatal chemical.

The federal government has disappointed all of us in the health care community with its changes in the last two days. Our Ontario college has strongly protested this federal move to reduce taxes, and we would like to publicly acknowledge the strength of this government in standing tough and saying that it will not reduce taxes.

This government is doing good things. We applaud this government for these things and urge you to do more. History will bear witness to the courage and responsibility demonstrated by this government of Ontario when you pass this legislation. Thank you.

**Mrs Cunningham:** Thank you, Dr Morris, Ms Katz, for appearing before this committee with, as I'm not surprised to hear from this group, a very strong presentation.

A lot of the people we have heard from have recommended changes to the act with regard to the banning of kiddie packs and the plain packaging. I think I'm correct in saying there is going to be some serious thought by this committee and we're probably going to put forth amendments in that regard.

What I am interested in, though, is this whole thing about the retailers, because we have an act right now that says you get fined if you sell to kids under the age of 18,

but no one's been fined that we know of, that kind of thing. So now we've got 19. I am interested in this licensing of tobacco retailers.

I also would like you to give your thoughts on a couple of other ideas. We've actually had, in London, the medical officer of health from the Windsor-Essex area tell us that he thinks we ought to go further and sell tobacco in the LCBO stores and that young people should be taking responsibility for their actions, that when they do break the law, there ought to be some fines for them. It could be community work; it might be monetary. Those are pretty strong opinions that won't be well received, we think, by the general public, but we'd like to have your opinion on those today.

**Dr Morris:** The issue of licensing retailers versus tougher enforcement of regulations to me is to some degree a manpower and feasibility issue. I like the thought of licensing, and whether it's through existing LCBOs or through a new tobacco agency, the licence fees would, I would hope, pay for it so that it would be a self-sustaining, self-funding system that would have built-in enforcement. Rather than trying to enforce corner stores and enforce gas bars and enforce all kinds of other places, let's limit it and let's licence it before the fact.

There's the old slogan for cigarettes, "I'd walk a mile for a Camel." Everybody remembers that one. People won't. If the nearest cigarette is a three-mile drive away, it's going to be tougher for a teen to smoke than if he can walk 100 yards to the corner store. So to put cigarettes into restricted locations such as LCBOs or similar agencies to me makes a whole lot of sense.

With regard to the issue of fines for youngsters who smoke, you and I discussed, Mrs Cunningham, the issue of individual responsibility for actions. Again, I see sense in this. I'm not willing to speak on behalf of my college on this. Individually, I would love to see that, in the same way that I think fines for people who don't wear bicycle helmets bears some sense. If those fines are funnelled back into tobacco cessation programs or if those fines could be applied towards getting enrolled in a tobacco cessation program, that's great, but trying to help people quit smoking is enormously difficult. I know. I try every day in my office. It doesn't work well. Hypnosis, Nicorette, nicotine patches and all of the other programs don't work well. What this disease needs is not better treatment but primary prevention. That's what this bill talks about.

**Ms Cheryl Katz:** The issue for the college is really one of where you can get the most cost-effective impact. If you're talking about after-the-fact sanctions, it presupposes that there is a mechanism in place to enforce those sanctions. It means the courts have to be able to sustain the work of the law enforcement agencies. It means that youth under the Young Offenders Act have to be treated appropriately and not just simply given a slap on the wrist. Otherwise, what you're doing is benefiting the legal system, benefiting the lawyers, and not really having much impact on the individuals whom you are trying to influence in terms of the smoking behaviour.

Sanctions may work if you can enforce them, but it's going to be arbitrary. You might find that there are going to be much more effective and cost-effective measures if

what you do is license, because then you're not so much dependent on external factors that really are out of your control.

**Mrs Cunningham:** One of the problems here is that I think we've all also agreed we're not going to talk about schools; we're going to talk about school property. This means in your city and mine the students are going to go on to the neighbours' property or down to the corner store. So to leave it with nothing I think is a big problem. That's all I'm saying. We have to think a little bit more about the practical implications of this legislation and how we deal with them.

**Dr Morris:** An article from the American Journal of Family Practice entitled "Preventing Teenage Tobacco Addiction" has a model school policy on tobacco. One of the items in that model policy is that students shall not be allowed to possess tobacco products on school grounds. That would certainly eliminate smoking on the neighbours' grounds because you can't bring cigarettes into the school.

**The Chair:** Just before going on to the next question, could we get a copy of that article?

**Dr Morris:** My apologies. I didn't think to bring enough copies, but you're welcome to this.

**The Chair:** The clerk will just take it and while we're finishing off, he'll get a copy made. Ms Caplan, we have time for your usual short, sharp, succinct question.

**Mrs Caplan:** I will try and be short, sharp and succinct. An excellent presentation from the college of family physicians.

I would like to explore the concept of licensing. I think the regional municipalities right now—certainly I know in Metropolitan Toronto—issue taxi licences, licences to restaurants that are going to serve alcohol. Do you see any problem with just expanding that mandate of existing bureaucracies to license retailers for the purchase of cigarettes—not health facilities, but other retail facilities? Use the same user-pay concept that you've expanded on but with existing bureaucracies rather than either creating a new government monopoly or a new bureaucracy.

**Dr Morris:** An excellent thought, Ms Caplan. My quick response there is that, yes, I do see a problem with it, and that is the enormous variability there would be between municipalities. In the county of Simcoe, in which I live, the city of Barrie, because of the efforts of a number of people in Barrie, has tough bylaws about smoking in restaurants and other environmental tobacco smoke regulations. The other municipalities in the county of Simcoe have none or very rudimentary bylaws, so if in a given municipality there are soft-spoken people like Ms Katz or me to address these kind of issues, then those municipalities will probably do well and the citizens in those municipalities will enjoy better health, thank you very much. But if in other municipalities there aren't these people, then such things won't happen. So I would like to see this as a provincial responsibility.

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**Mrs Caplan:** What if the province were to establish the standard and require municipalities to enforce? We frequently have that relationship also, especially if it's not



going to be a cost to the municipality, if it's a self-funding mechanism. Would that resolve your concern?

**Dr Morris:** That would help. Thank you.

**The Chair:** Thank you both very much for coming before the committee this afternoon for your presentation.

COUNCIL FOR A TOBACCO-FREE REGION OF PEEL

**Mr Raymond Langlois:** Thank you for allowing us this opportunity to speak to you this afternoon. I'm here to speak to you on behalf of the Council for a Tobacco-Free Region of Peel. Our representatives include the Heart and Stroke Foundation, the Canadian Cancer Society, the Peel health department, the Lung Association, the boards of education, separate and public, private citizens, pharmacists and a number of other concerned folks within the region.

We're all here for one common goal, and that is to prevent youth from smoking. I guess in the long run the bottom line is to decrease tobacco consumption, certainly to decrease disease and death and to decrease the health care dollars that we're going to spend this year and for the next number of years forthcoming.

**The Chair:** Excuse me, just before you continue, just to help Hansard, could you just introduce yourselves so we know who's who.

**Mr Langlois:** Yes, I would like to do that. My colleague with me today is Mr Richard Gallagher. He's principal of St Stephen school and he's going to be speaking to you shortly on one of the issues that I'll be dealing with as well.

**The Chair:** By the process of elimination, we know who you are.

**Mr Langlois:** There you go.

Certainly, in light of the recent federal tax drops, now is an especially important time to move quickly on some of the things that you have highlighted in Bill 119, in particular the pharmacy ban and plain packaging. It's rather unfortunate at this time to see what the federal government has come up with in the past few days and to see that a pack of cigarettes this morning was \$3.25, I believe. The whole thing about kiddie packs and everything else is very upsetting, very disturbing.

**Mr Wiseman:** You don't need kiddie packs any more.

**Mr Langlois:** No, you certainly don't.

I think this provincial government should be congratulated for its efforts in introducing Bill 119. I believe this represents the first major initiative to address tobacco as a serious health issue in this province. We commend their actions thus far. In dealing with tobacco as the number one cause of death, it must be emphasized that this should be a non-partisan priority for all parties, and from the questions I'm hearing—I heard a few this morning and this afternoon—I certainly feel that it has that approach.

It is regrettable to see the federal government consider tobacco tax reductions at this time, when over the past 12 years taxation policies have played a significant role in reducing consumption, especially in youth, who are very price-sensitive. Provincial governments should be lauded

for taking a very tough stand thus far against any tobacco tax reduction proposed by the feds and certainly we hope that you will maintain that tough stand. We see that you're feeling perhaps that you're being painted into a corner at this point, but I believe that the principle is very, very obvious and I think we should be standing for the principle, regardless of what is happening in terms of the tax at the federal level. It's unfortunate that there are some other political things that are happening between the feds and Quebec, and I believe that there are other influences here at work, but this is a health issue. Let's keep that in mind: This is a health issue, not an economic issue, not anything else but a health issue.

In proposing the current legislation, there are several positive steps that have been made, particularly, in order, the stronger non-compliance penalties, prohibition of vending machines and the elimination of tobacco in pharmacies. However, I believe that Bill 119 does fail to address several key areas that are of particular interest to residents in Peel, especially in light of a recent study that we conducted. Some of those areas include licensing of retailers who sell tobacco, prohibition of sales for specific time periods should a retailer commit a third or subsequent offence under your section 15, the prohibition of smoking in all public places, the establishment of appropriate enforcement practices and the expansion of workplace legislation.

To effect positive changes in the health of all Ontarians, it's paramount to initiate comprehensive legislation and education strategies together. Easy access to tobacco by youth has been identified as a significant problem in this province.

You all know the figures, the 13,000 deaths every year. You know that 90% of these people begin when they're in their school years. Over 3,000 youths are beginning smoking every month, so we know where it's starting. I think these facts alone demonstrate the need for this government to pass strong legislation and to prevent additional youth from becoming addicted.

This document highlights several areas of Bill 119 which could be improved with amendments or added provisions or regulations. Our recommendations certainly include to establish a provincial licensing system for retailers, like the LCBO—they are both licence-type systems—designating all public places smoke-free; implementing plain packaging with prominent warnings; prohibiting sales in pharmacies and vending machines immediately and not waiting for the one-year period to pass by; maintaining appropriate taxation policies, at least at the provincial level, and encouraging and lobbying at the federal level; ensuring adequate enforcement of any legislation that is passed forward; and evaluating and modifying the strategies for effectiveness as we go along.

These recommendations are further developed in the paper. I'm going to address one particular area that we feel is very pertinent. It's a very concrete example of something that we conducted in Peel.

In Peel region, which is Brampton, Caledon and Mississauga, the Peel health department conducted a study last summer which determined that 80% of retailers were willing to break the law and sell tobacco to youth.

That type of study has been conducted in a number of other areas in this province and across the country and it shows probably quite similar rates.

It was determined also that 98% of these retailers did not request to see youths' identification. Pharmacists were more compliant with the law, while convenience stores and restaurants were least compliant, somewhere in the 80% to 89% range of non-compliance. There's an attached summary that you'll see that will further clarify the study. Also the original study is with the clerk and you can have a look at it as well afterwards.

These are cold, hard, disturbing facts which leave an indelible impression about the abrogation of their responsibility to youth and the absence of appreciation for the health consequences of their actions.

In addition to these results, we have also received numerous reports from parents, school personnel and concerned citizens about youth not only accessing tobacco from retailers but purchasing single cigarettes on a regular basis. My colleague here today has confirmed reports of over 20 students that they indeed purchase single cigarettes from a local retailer at 35 cents apiece. This is a clear violation of the federal Excise Act and provincial Minors Protection Act, yet it's a common occurrence in our region and in other regions. My colleague will speak to that shortly.

It is clear that the current legislation and accompanying enforcement have failed to ensure compliance with the law. We need to go further for retailers to adhere to the law. A licensing system should be established whereby retailers can have their licence revoked if they commit an offence for selling tobacco to youth. Retailers will be more accountable. They'll have entered into an agreement, they'll be aware of the conditions as to why they're getting that licence and what goes along with getting that licence, what the responsibility is.

As mentioned in the previous presentation, you can set a licensing fee, be it at the municipal level or if it was an LCBO type of system set up, and that licensing fee can be commensurate with the cost of administration and enforcement for that particular program.

Also, in raising that age to 19, you've already got in place age-of-majority identification which could become the standard request by retailers or whomever is using this particular system.

Since most smoking behaviour begins with youth in their school years, it's imperative that appropriate measures be established to prevent access to tobacco. A study in Nova Scotia demonstrated that the average age of initiation is 11 years—11 years old. They're starting very young. It has been estimated that almost half a billion dollars are spent on tobacco by youth. Most of these youth obtain their tobacco from retailers. Theoretically, it shouldn't be possible; however, the shortcomings of law and enforcement in this respect are rather obvious.

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There are no details about enforcement released by this government at this time. I think we need to realize that without adequate human and financial resources to support this act, legislation will be futile. In the case

where the present system proves to be ineffective, and I speak of a system where you're talking about increasing fines, we should in fact put in place a licensing system either where retailers have to purchase licences or something along the lines of an LCBO, which would go much further in taking care of any compliance problems. You'd have a better control over distribution and the like.

I think the pervasiveness of this product and the ill effects of tobacco and smoking must be stopped. Each preventive measure that we implement with this legislation can save thousands of lives. However, each measure that's delayed can cost thousands of lives. I hope that this group and all of us who are supporting you in putting forth Bill 119 will ensure that we pass comprehensive and effective legislation that will have a very significant impact on the health of current and future generations.

I'd like to pass along now to Mr Gallagher, who will speak to you about a particular example.

**Mr Richard Gallagher:** I guess giving an educator and a politician three minutes doesn't make much sense, does it? I've been in education for over 30 years and I can assure you that my cold at the moment was not cigarette-induced. Having had a father who died of lung cancer six years ago—and I'd never smoked, as it so happened—I heartily congratulate both the government members and the members of the opposition for taking a strong stand and working together. I've changed everything as I was listening, so I'm going to ad lib.

Children are smoking as early as eight and nine years old, and not 10. The 23 students in my school range in age from 9 to 13. I sought them out when I was called by a teenager from the high school to tell me that her sister had been buying cigarettes at the corner store. I went around and I asked the children to come down and see me if they had been buying cigarettes and assured them that there would be no phone calls home. As a parent, you may or may not agree with me on that, but otherwise of course they wouldn't have come. I've only got 440 students in my school, so when 23 came to me, probably a lot didn't come to me. You can imagine the number who smoke. It's in a very affluent, upper-middle-class area of Brampton.

I then called the police department and advised them that I had these people who were willing to testify, or commit themselves, and they told me they would not act. It was not in their jurisdiction. I'm not a lawyer, although my brother is, and I've been listening to him long enough. I said, "But if it's against the law, then you should be acting." They refused and told me it was a Brampton bylaw problem.

So I called the bylaw department. A gentleman called me. He did come to the school, we chatted and he said he would visit the store. But he said to me, "Mr Gallagher, we've never fined anybody, but I'll go over." He did and he reported back to me that he had done so. He called me a week in a much more agitated tone of voice when he found out that his own 12-year-old daughter had just bought cigarettes at the same store. A week after he had warned them not to sell cigarettes, his own daughter went in and bought them. So he was much more on my side but still said nothing ever happens.



My conclusion, I suppose, is that if you're going to change the law, you have to be prepared to enforce it, and if you're not prepared to enforce it, don't change the law. The cigarette-Quebec reservation business is a case in point.

I lean very strongly to a licensed approach. It's not been my experience that older children are selling cigarettes to younger children. The younger children are buying their own, and they were buying them singly at this corner store.

I called all my students in and had an assembly. We talked about what had happened. I was going to put a letter out to my parent group, but our board lawyer advised me that it might not work out quite the way I wanted. I'm kind of sorry I didn't do it anyway; I still might.

I do strongly feel that raising the age to purchase and licensing corner stores will not solve your problem. They're not going to stop selling cigarettes if they're not going to be fined. I'm not sure if as a taxpayer I want to pay 100 more people to go out and fine the corner store for selling cigarettes. I really urge that you go to a licensed approach.

One last comment about the doctor who mentioned that they shouldn't have cigarettes on school property: I think we would find ourselves, as educators, in dire straits if we started physically searching children to see whether or not they had cigarettes. I think you can imagine the fallout from that one. It is a problem. They are starting at eight and nine years old. They are buying their own cigarettes, they're not getting them from older brothers or sisters, and the corner store is definitely selling them to them.

**Mr Jim Wilson:** Thank you for your presentation. It strikes me that you're right on in your latter comments about enforcement. When I think of rural areas of the province, we don't have bylaw enforcement officers. Even a big place like Wasaga Beach has one or two bylaw enforcement officers perhaps in the summertime. We don't have 24-hour policing. We don't have enough police as it is. Once you get outside of Metro, there's an entirely different world out there, as you can appreciate. Certainly, enforcing tobacco laws is not high, as far as I'm aware, on the police agenda. They can barely respond to the B and Es in the Stayner and Nottawasaga and Collingwood area, for example. In fact, it may take three days to investigate a break and enter of your house.

This is the question. It seems to me if you go to a licensing approach, you also need enforcement. We've been floating around the idea that perhaps we should put some onus on the young people themselves under the age of 19. You'd need a phase-in period or something to exempt perhaps those young people addicted to tobacco now; but if we put some onus on them in terms of saying that tobacco products should be treated the same way we treat alcohol, and that is, illegal under the age of 19 to possess or smoke. They do that, in my understanding, in one jurisdiction in the States where there's a \$25 fine associated and also a licensing system and sting operations. But at least there's some onus on the young people and they take some responsibility. What do you

think of that?

**Mr Langlois:** You mentioned two pieces that are important. You mentioned something about sting operations. We carried out a compliance survey. It's not a sting operation, because we didn't identify the retailers nor were they fined or anything along that line. By carrying out compliance operations—they've done this in a number of communities. I can think of Edmonton, I can think of Woodridge, Illinois, where they did implement stiff fines, and if a store was investigated and found to be selling, a stiff fine was applied the first time, if it was \$2,000 or \$5,000, and in a third offence maybe \$10,000 or their licence was revoked. In some cases, the licence was revoked on a first offence. If investigated and found to be guilty, first offence: licence revoked, no chance. That works. I think that can work, and I think we can use that in varying degrees. There are any number of ways. You can involve kids, obviously, in this. We used three 16-year-olds who were interested in working on this particular project with us.

The other area that I'd like to address is, you proposed something about fining children for possession of tobacco.

**Mr Jim Wilson:** We do it for bicycle helmets.

**Mr Langlois:** That may or may not work.

**Mr Jim Wilson:** We'll be fining guardians or parents, under a certain age.

**Mr Langlois:** Right. We can fine a retailer, and if you fine a retailer, right away you're eliminating the source for maybe 150, 200 or 500 kids who are passing through that store. It's easier to go after one or two or however many retailers than it is to go after thousands of kids. If you're talking about manpower, there is that difficulty right off, which makes it very difficult.

There is also the other problem of victimization, in terms of health promotion theories, in going after the kid who is carrying a little bit of tobacco, something along that line. I'm not sure that it works. It needs to be studied further perhaps.

**Mr Jim Wilson:** We've heard the victimization argument, and I can see both sides of that one. But I think young people should take some responsibility, and I think it does warrant further investigation, because the young people we've had appear before the committee have told us, "It doesn't matter if you put the corner Becker store out of selling cigarettes; we'll just go to another one." Basically, they told us that if they want to buy cigarettes, they'll figure out a way to buy cigarettes no matter what we do: raise the age, put \$100,000 fines on the retail stores or whatever. That's the model we've been using. Your own study, and I'm reading from page 19, shows it's not really working all that well, so that's why we're floating the idea.

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**Mr Langlois:** There's no enforcement at this point and that's why it's not working. There is no enforcement.

**Mr Jim Wilson:** I can see a licensing system—

**Mr Langlois:** If you were to set up something along the lines of an LCBO or use the current LCBO, that's a form of licensing system as well. You've already got the

system in place. It works for liquor; why can't it work for tobacco? As a number of other people have highlighted previously, I think it falls along the same line in terms of: it's a lethal drug, first of all; I'd like to see it banned altogether. Unfortunately, I don't believe we're going to arrive at that conclusion at this point in time. Maybe 20, 30 years from now, if it's placed under the hazardous products act, that might be a step in the right direction as well.

**Mrs Haslam:** I'll be very brief because actually I agree with Mr Wilson. It is important and I agree with you—I know that's hard to believe, Mr Wilson, but I do agree with you right now. I'd like to commend you on—

**The Chair:** The Chair is happy to hear this.

**Mrs Haslam:** I know. Such a wonderful way to end the afternoon. First of all, I want to commend you, sir, for coming forward. I didn't realize it was really at the eight- or nine-year level. I knew it was getting low, but I think your coming here today has really drawn that out and drawn a much stronger picture for those of us on the committee looking at the age of the people involved. I want to thank you for coming and doing what you can in your own school.

I just want to be very brief and say that I agree with my colleagues and with you. It does boil down to enforcement and no matter whether we go with what's in the legislation on the statutory ticketing, a not-allowed-to-have-tobacco-on-the-premises type of model or whether we go a little further into a licensing situation for everyone and a self-financing, it still boils down to the enforcement and whether we have the funds to put into that, and whether we have the person power to put into that. I'll be very brief and just say I agree.

**Mr Gallagher:** Just as an educator, I think we mustn't give up on the idea that education is winning. I don't mean just in-school education. In the general public, the number of students who are smoking overall is declining. An example where education has worked parallel would be on littering and on recycling where some years ago all of us and the children were throwing everything away and we really are turning a corner on that. I think the more education we have by schools, by homes, we are going to get much more relevant than try to fine a 12-year-old \$25 for having cigarettes.

**Mrs O'Neill:** I don't know how relevant it is, but many years ago I taught for the South Peel Board of Education, as it was called at that time, and enjoyed it.

You didn't mention at all the presence of contraband and that hasn't come up in many of the educational presentations in this area, though it has come up in other parts of the province where we've been holding hearings. Could you tell me whether you feel that's a problem? In London, for instance, they feel it's on every school property, the presence of contraband. Educators told us that on Monday. Do you feel there are car trunks accessible to all your students?

**Mr Gallagher:** You must understand that I had 19 years of teaching at the high school level and administering, and now I'm at elementary level. In an elementary school, no, I would not perceive that there is a great deal

of that occurring. The environment is so different. In an elementary school, most of them, if they see a car stopped and a trunk open, you'll have eight kids running in to tell you there's a stranger on the property and it may in fact be a parent delivering lunches. If a surveyor, God willing, pulled out a surveying, "We have a rifle on the property."

**Mrs Haslam:** Which is good.

**Mr Gallagher:** Which is good. Yes, I don't mean to be facetious. I would imagine, at the high school level, talking to my colleagues, because we have a family of schools, that obviously if people are smoking and they can buy cigarettes contraband, they're going to do it. I wouldn't be surprised that it does occur, although I don't have firsthand proof of that.

**Mrs O'Neill:** Okay. The other thing I wanted to ask you, and this was seen to have a very high profile—in Sudbury yesterday where cessation programs in the schools are part of the regular curriculum. This, mind you, I think was a high school presentation, but they were talking about it being part of the credit program and also involving both the support staff and the custodial staff in these programs with no docking of pay. I wondered if the Peel board has anywhere near that kind of presentation. From what you say, it perhaps needs to be part of the curriculum at the elementary.

**Mr Gallagher:** I'm going to put two hats on. I used to work for the Peel public board and now I'm Dufferin-Peel separate, but I'm on another committee for both boards, so what the heck; but only one pays me.

Both boards have smoke-free schools, board buildings, vehicles and property. Both boards have sponsored how-to-quit seminars for their employees and both boards, I believe, have censured—I can't prove that, but I believe from what I've heard—employees who have been smoking on property. So yes, they are both very active—employer-employee.

Studentwise, both boards are very active in the classroom in phys-ed curriculums, the health curriculum at the high school level and certainly also at the elementary school level. In fact, Raymond has sent me packages on other schools and I've included that on school letters that go home to parents.

The average elementary child is quite aware of the dangers of smoking and if we can just prevent them from being hooked at 10, 11 or 12, I think we've got them saved. They're not unaware of the dangers and they are being educated. I would say that in Peel the schools are very active in preventing smoking through education.

**Mrs Haslam:** I'd like a clarification.

**The Chair:** I'm sorry. We've really gone over the time and we have a full afternoon. Perhaps you could just slip out and get that. I want to thank you both for coming before the committee.

#### EQUALLY HEALTHY KIDS

**Mr Michael Polanyi:** I'll just introduce myself and the others. I'm Michael Polanyi and I'm the coordinator of the Equally Healthy Kids project. Next to me is Theresa Martin; she is the volunteer co-chair of Equally Healthy Kids, and Julia Sherbot is also a volunteer, a



member of the steering committee of Equally Healthy Kids.

Thanks a lot for giving us the chance to come here today. Just a word about Equally Healthy Kids: It's a project in the south Etobicoke area and encourages and supports community action on health issues in that neighbourhood. We are here today because we are concerned, as members of Equally Healthy Kids, about the health implications of smoking and we also perceive it as being largely a youth issue. You've heard before already that most smokers start as youth. The last presenter mentioned that. You know the influence on health. You probably know that two billion cigarettes a year are smoked by youth under the age of 19. You're probably aware that the incidence of smoking among grade 7 students is up 50% since 1991. I think what's important is to understand why youth smoke. If we do understand that, then we can take action to stop youth from starting to smoke.

That's one reason, a major reason, we support Bill 119 and we commend the NDP government for pushing this bill forward. We encourage opposition members to support the bill. We feel that it's a major step towards addressing the causes of smoking in two ways in particular: One in reducing accessibility to tobacco by youth, and that's something that Theresa is going to speak a little bit about and, secondly, by delegitimizing, reducing the legitimacy of cigarettes. That's what Julia is going to talk about, particularly in relation to pharmacies and the ways that pharmacies legitimate the use of cigarettes.

A third factor that I'll just touch on, which is in our report, is that we feel it's important to get at a third cause of smoking and that's the marginalization of youth in our community and in other communities. When I'm speaking of that, I'm talking about the fact that a lot of youth feel they are excluded from their communities. They feel like their voice is not heard. They feel like there is a lack of recreation opportunities, there's a lack of opportunities for youth to participate meaningfully in their communities and to be recognized for that participation. Youth also feel stereotyped by the few youth who are often in the media. It's usually bad news we're hearing about youth and not good news.

1520

So youth don't feel valued. Many feel angry and they don't feel good about themselves, and they use cigarettes to improve their self-image. They use cigarettes to establish their independence and to be adult-like, because even though adults often say, "Don't smoke," adults do smoke, so it is seen as being adult-like. They use cigarettes to deal with stress that they face in their lives, boredom and to fit in as well.

We feel that we need to pursue Bill 119. We also need to provide ways for youth to start to establish their independence and take risks in healthy ways, so we've included something on that in the report. Now I'll just pass it over to Terry.

**Ms Theresa Martin:** Thank you. I'm in favour of licensing cigarette stores. Any store that sells cigarettes should have a licence, and if they sell to minors, they should lose that licence. In our area, it is very, very easy

for any age child. I've sent my nine-year-old granddaughter, just for the fun of it, to see if she could buy me a package of cigarettes, and she did. They gave them to her. They sold them to her. No problem. Any child can buy cigarettes in the stores.

I think making cigarettes harder for children to buy would work much better than preaching to them, "Don't smoke," because I find that the more you tell teenagers not to do something, that's what they're going to do, because you told them not to.

I would like to see the cigarette machines taken out of restaurants, doughnut shops, anyplace where teenagers have complete accessibility to and hang around, because if they can't buy them in the stores, who's going to stop them from taking them from the machines? They're very easy to get. Also, in the corner stores, those five-packs of cigarettes: You give your child \$2 to buy a Coke or something with their lunch, they can go and buy a five-pack of cigarettes or they can buy one or two cigarettes. They should be against the law.

**Mr Wiseman:** They can probably buy a whole pack.

**Ms Theresa Martin:** For \$2?

**Mr Wiseman:** Almost.

**Ms Theresa Martin:** Where?

**Interjection:** Places.

**Mr Jim Wilson:** Let's not advertise.

**Ms Theresa Martin:** I would like to see alternatives offered. Wherever cigarettes are sold, I would like to also see signs that advertise about the gum they can chew rather than smoke, for anybody who's interested. Advertise the patch right alongside where cigarettes are sold. Make them affordable for teenagers, for anybody, any teenagers who would like to quit smoking.

Kids start smoking in public school systems, not in high school. By the time they reach high school, they're steady smokers. In grade 6, there should be a program, not preaching "Don't smoke. It's going to do this to you; it's going to do that to you." Most children are well aware of it. They don't listen. They hear you; they don't listen. Just let them see films of what's happened to somebody who was smoking for a period of time. They're on these breathing machines, their lungs are so badly damaged. Let them see pictures of lungs before you started smoking and after you've been smoking for a few years. Let them see visually what's going to happen to them if they continue smoking. I would like to see this as a program in the public school system, before they reach high school, and carried on into high school.

For youth who are already smoking, I would like to offer support for those who would like to quit by, like I say, making deterrents affordable, like the patches and the gums. Offer smokers a smoke-free camp, a couple of the weeks in the summer, to encourage them. Make non-smoking the in thing in teen language. Make it cool not to smoke. Promote programs that make it cool not to smoke instead of being the in thing to smoke.

I think that's about it.

**Ms Julia Sherbot:** The community that I live in, sadly, is not unique, and this is the situation that I wish

to address. Most specifically, my access to two pharmacists is my only access to pharmacists in the area. Both pharmaceutical outlets sell cigarette and tobacco products.

The promotion and use of tobacco products is markedly evident in my community, on the principal streets, in the school yards, janitors smoking outside of school yards. There is no visible promotion of cessation events. There's no visible promotion of healthy adaptation in relation to stopping smoking. There are no notices on store windows, in store interiors or on telephone poles, nothing at all that encourages young people, indeed even encourages adults, to stop smoking.

Participating in this culture of disease promotion and addiction maintenance are the only two drugstores most immediate in a very active part of New Toronto.

We have no quarrel with the professionalism with which prescriptions are dispensed and interpreted, but we cannot begin to respect the marketing process that offers service and advice at the back of the store on minimizing and stabilizing disease while promoting cigarette use at the front, in part through association with sweets, magazines, sports cards, troll pencils, colourful lighters and other desirable products. The association of cigarettes and these products is made starting in infancy. For those who are struggling not to begin or to stop smoking, there are the herbal cigarettes, a ginseng connection: an extremely profitable delusion.

We would like to see pharmacists in our community promote health; that is, facilitate healthy adaptation to the stressors in life, emotional and physical. Why do they not trust their professional education to bring to this community products and processes that promote health? Classes relative to nutrition, responsible use of medication and elements of fitness are all associated with the legitimate products that they dispense. Their contact with residents and other health professionals provides a wonderful opportunity for them to promote health. If they are to be respected, there must be integrity within individual practice.

It was suggested in this forum some days ago that pharmacists be allowed to continue the selling of tobacco products since they're best able to promote cessation counselling. The mere mention of counselling without any further elaboration, to my knowledge, was very well received in this forum.

But effective counselling involves a contract, a commitment of time, a building of trust by both client and professionals. Can pharmacists provide the time and, moreover, can they build trust with someone trying to quit smoking when they are simultaneously promoting tobacco sales?

There should be a choice for pharmacists in this province. Do they wish to serve clients or do they wish to serve customers? Several groups within the profession have argued that one must do both to exist in the retail climate of today. Why then are veterinarians, who sell prescription and non-prescription products, able to maintain their practice without selling tobacco products at the counter? Natural food stores are able to make a holistic decision.

More true to the intent of the pharmaceutical discipline are the professional peers who are willing to support each other in the decision to withdraw from the process of doing harm. Pharmacists should not be permitted to disguise harm with good.

**The Chair:** Thank you. We have a few minutes for questions. Ms Haslam.

**Mrs Haslam:** Actually, no, Mr Chair.

**The Chair:** I'm sorry. I anticipated there would be.

**Mr Wiseman:** This whole question about youth and the beginning: You raised a really good point. It's interesting that when you look at these vending machines, the cigarette packages are about eye level for a two-and-a-half-year-old, a three-year-old. So you're absolutely right. It starts early, and the association of cigarettes with other cultural things that are positive means that everything is positive. So you build up these connections. It's the way you build a good argument, you know, positive, positive. If you want to make somebody look bad, you put a negative in.

1530

What we heard from some young people in Sudbury is that they have started in their schools to talk about reduction. I suggested that maybe if young people who wanted to quit and couldn't talk to younger people who hadn't started, that might be useful. How do you feel about that as an option? Have you tried it? Do you know anything about that?

**Ms Theresa Martin:** No, we haven't tried it, but I think it's a good option. It's making them feel useful and giving something to the younger children, knowing that he's a teenager but he doesn't want to smoke, but he's doing it because he's addicted to it. I think it's a very good idea, and we could maybe have teenagers who have smoked and gotten off it be counsellors at camps for younger children who do smoke at the smoke-free camp, if we ever got one.

**Mrs O'Neill:** Thanks so much for your idea about the smoke-free camp. We haven't had that suggestion. I think it's excellent.

You say you have a recreational drop-in centre with 300 youth. Is there a smoke-free area to that, or how do you, what should I say, practise what you preach in that drop-in centre?

**Ms Theresa Martin:** I don't think they're allowed to smoke. They have to go outside for a cigarette, as an incentive.

**Mrs O'Neill:** So you have got a no-smoking rule there?

**Ms Theresa Martin:** Yes.

**Mrs O'Neill:** And you don't have too much difficulty with that?

**Ms Theresa Martin:** No, they go outside and smoke. They don't like it, but they have no choice.

**Mr Polanyi:** A lot of the youth who do come to the drop-in centre are unfortunately addicted to smoking. As we mention in the brief, actually what we do with them at the centre is try and give them chances to identify issues that are of concern and take action on those issues.



Well, one of the issues they identified to be of concern was having an indoor smoking area at the centre. So that was kind of a difficult issue for us, because we don't want to encourage that, but by the same token we want to encourage youth to be able to be part of their community and to work through some issues, to problem-solve.

We've said to them, "Sure. Go ahead and check the health regulations on the building and talk to the non-smokers in the building and talk to the staff and start to deal with the issue of how the staff feel or parents would feel if underage youth"—so they're working through the issue a little bit, and as Terry was saying, they're not being preached at from the start but they are starting to work through it and maybe realizing that there's not going to be a lot of support for them. That's why it's important that there isn't smoking allowed in malls and public places and all this so they don't push things.

**Mrs O'Neill:** Thank you for expanding on the answer.

**The Chair:** Thank you very much for coming forward. We certainly wish you all the best, not only in this work but I know something of your organization in terms of the other things you're doing. It's extremely valuable.

WILLIAM BRODERICK

**Mr William Broderick:** My wife and I are here today because we believe, along with the chief medical officer of health for Ontario, that tobacco-caused or -related diseases is our number one public health problem. According to Dr Schabas, more than 13,000 Ontarians die prematurely each year due to tobacco-related diseases, and that's a lot of people. As Dr Schabas points out in his 1991 report entitled *Tobacco and Your Health*, it's almost five times the number of people who die from traffic accidents, suicides and AIDS combined. Also, as he points out, these deaths are preventable.

When we have an outbreak of flu, hepatitis, rabies, pneumonia or tuberculosis everyone gets very excited. We say we have an epidemic on our hands and we take steps to try and prevent it. Well, what do we call 13,000 deaths a year from tobacco-related diseases?

As a society, I believe it is incumbent on us to recognize the tobacco epidemic for what it is and to try and take preventive measures so that people can live safe and healthy lives. Bill 119, *An Act to prevent the Provision of Tobacco to Young Persons and to Regulate its Sale and Use by Others*, is such a preventive measure. Bill 119, if and when it becomes law, will not prevent people who are already addicted to tobacco from smoking. It will not make tobacco products significantly more difficult to buy, but it will make it more difficult for children and young people to purchase tobacco products and so prevent many of them from entering the stream of replacement smokers taking the places of the thousands who die every year from the tobacco habit or who quit.

Studies show that people who do not start smoking as children or teens are unlikely ever to take up the habit at all. Bill 119 therefore has the potential to save many thousands of lives in the years ahead.

In speaking to you today I want to talk about four specific areas of Bill 119: tobacco retailing in phar-

macies, smoking in schools, smoking in public places and plain packaging.

Taking these one at a time, tobacco retailing in pharmacies: I'd like to begin by quoting from the *Principles of Ethical Behaviour of the Canadian Pharmaceutical Association*, which says that, "A pharmacist shall not participate in any advertising or promotion program which might...encourage misuse or abuse of drugs."

Also, quoting from the *Ontario College of Pharmacists' code of ethics*, "A pharmacist should never knowingly condone the dispensing, promoting or distributing of drugs...which lack therapeutic value for the patient."

Tobacco is an addictive drug, one of the most addictive there is, and pharmacists have for years been participating in its advertising and promotion. They have for years been encouraging its misuse and abuse. They have for years been dispensing a drug that has absolutely no therapeutic value for anyone. Tobacco makes people sick. It kills.

Their own code of ethics, their own principles of ethical behaviour, say that they shouldn't be doing it. It's a conflict of interest of the worst sort. As health professionals they should never have gotten into the business of retailing tobacco.

Over the years the Ontario College of Pharmacists has repeatedly asked pharmacists to voluntarily stop retailing tobacco products. A few hundred drugstores in Ontario have in fact done so and they are to be commended for upholding the integrity of their profession. The great majority, however, have simply ignored the request of their own regulatory body that they stop their unprofessional behaviour, as if tobacco required no more regulation than candy bars and chewing gum. As a final resort the college, in June 1991, asked the government of Ontario to legislate tobacco out of our drugstores. The provisions of Bill 119 dealing with pharmacies are the government's answer to that request. I hope that this provision will pass.

A whole year of grace? In an effort to be fair, the proposed legislation gives our drugstores a whole year of grace after it comes into effect to make the necessary adjustments. I believe that time frame is too generous. The diehards have already had more than enough time to make the necessary adjustments. I would suggest to you that three months, or six at the most, are sufficient.

1540

Remember, it will probably be summer or fall by the time this bill is finally proclaimed into law, three full years after the Ontario College of Pharmacists made its request to the government. Remember also the several hundred pharmacists who have demonstrated their integrity and professionalism already by making the necessary adjustments.

The diehards say that they want a level playing field. I suggest to you that January 1995 is late enough to give it to them, with their brothers and sisters in the pharmacy profession who have already shown their responsibility to society by removing tobacco from their stores. I urge you to shorten the implementation period so as not to extend it beyond January 1, 1995.

Regarding smoking in schools, we're pleased to see that smoking is not to be permitted in schools. However, in order to remove any confusion as to where smoking is or is not permitted, I would like to suggest that the grounds and property on which the school or institution is situated also be included so that this subsection would read as follows: "A school, post-secondary educational institution or private vocational school, including the property or grounds belonging to it." The purpose of this subsection, as I see it, is to remove as far as possible the example of adults smoking on school property or premises. So let's go all the way and include the entire premises.

Regarding smoking in public places such as retail stores, laundromats, barbershops, hairdressing salons and public transit shelters, these provisions are certainly welcome, but do they go far enough? It seems to me that if we're going to treat the issue of secondhand smoke seriously, we have to do considerably more than that.

If we're going to prohibit smoking in retail shops and similar establishments, it's just as easy to go the extra millimetre and prohibit smoking in shopping malls, for example. At the present time shopping malls present a serious problem for many non-smokers, especially people with allergies. Along with shopping malls I would strongly recommend that smoking be regulated in restaurants, sports arenas and other places of public assembly, hotels and motels and even public washrooms. Washrooms, by the way, are often overlooked. Like elevators, they're small, confined places and stale tobacco smoke in them smells really terrible. Please include washrooms.

Bearing in mind that environmental tobacco smoke is now recognized as a group A or known human carcinogen, I would recommend that as a general rule all public places should be non-smoking except for designated smoking areas. Adopting this suggestion would have obvious benefits not only for the public but also for the people who are employed in these places.

Plain packaging: It isn't clear from my copy of Bill 119 if plain packaging is being considered or not. But if we're really serious about wanting to dissuade young people from smoking, then mandatory plain packaging or generic packaging is the way to go.

According to the studies that I've heard and read about plain packaging, kids aren't even interested in smoking cigarettes that come in plain packages. Packaging is part of the experience of smoking. Take away the attractive, colourful, glamorous package and suddenly smoking isn't cool any more. So think plain packaging. It could be the single most important step towards a tobacco-free society.

To summarize my recommendations: The implementation period for pharmacies should be three months, or six at the most, after the act comes into effect; include the entire premises and grounds in the prohibition on smoking in schools; make all public places non-smoking except for designated smoking areas; and finally, adopt plain packaging.

In conclusion, I'd like to leave you with two thoughts. First, the tobacco issue is a health issue. The purpose of the Tobacco Control Act is to protect our children and young people. Almost without exception, people start

smoking as children or teens. When they see cigarettes being sold in drugstores and being smoked almost everywhere, it's natural for them to think that the things can't be as bad as we've been told. My own grandchildren have used this argument on the two of us. We've got to stop giving kids mixed messages about tobacco. It's not like candy bars and chewing gum; it's deadly stuff.

Second, to borrow a phrase from an old tobacco advertisement, "You've come a long way, baby." The Ontario Legislature has drafted a bill which, if it becomes law, will make history. But history is not made by faint hearts. It's not made by half-measures. It's not made by caving in to those who have a vested interest in the status quo. History is made by making the hard decisions and sticking with them and taking bold steps. Unless we go the distance and pass the Tobacco Control Act, hopefully with a few improvements, we haven't gone anywhere. Let's do it. Let's make history. Let's show that we have indeed come a long way. Pass Bill 119.

**The Chair:** Thank you both for your presentation.

**Mr Eddy:** Thank you for suggesting some improvements to the bill. That's very helpful. One of the things that we've been asked to look at by several presenters is the matter of licensing any establishment that would be allowed to sell tobacco products, and the other one is to go even further and have it only at government outlets, a system like the liquor control board. What would your opinion be on even tougher measures to control sales like that?

**Mr Broderick:** I would think that would be a good idea.

**Mr Eddy:** To go even further.

**Mr Broderick:** That would have my whole support. I think licensing would give the government a little better control of the tobacco situation.

**Mr Eddy:** Fine. Thank you very much.

**The Chair:** Thank you again for your presentation and for coming down from Shannonville to be with the committee this afternoon. We appreciate it.

#### ROM NO SMOKING COMMITTEE

**The Chair:** If I could then call on the ROM No Smoking Committee. I'm assuming that this is the Royal Ontario Museum, or am I wrong on the ROM?

**Ms Lydia Bell:** The Royal Ontario Museum, yes. The non-smoking committee, not the ROM.

**The Chair:** We want to thank you all for coming this afternoon. If you would be good enough to introduce yourselves and then please go ahead with your submission.

**Mr Robert Biggs:** My name is Bob Biggs. We four are members of the Royal Ontario Museum No Smoking Committee. I hasten to add that this committee is in no way sanctioned by the museum.

We wish to thank your committee for this opportunity to present our brief on the smoking policy at the ROM and at other similarly publicly funded—I was going to say institutions but I don't think that's quite correct—centres.



I'd like to introduce you to Marilyn Robertson, Lydia Bell and Sylvain Smeets, each of whom will make a short presentation to, firstly, outline the problems that we have had with the museum's smoking policy in its main floor cafeteria, and secondly, to request that the proposed tobacco act be amended to exclude smoking not only in the Royal Ontario Museum but in all publicly funded museums, art galleries and science centres. So to start off, Marilyn Robertson is ready to go.

1550

**Ms Marilyn Robertson:** Some background: We frequent the ROM once a week to attend and participate in the University of Toronto School of Continuing Studies, university lunchtime lecture series. After each session, we go to the main floor cafeteria to discuss the lecture and to eat lunch. It is our experience that the concentration of cigarette smoke from the smoking area wafts to the entire eating area and furthermore to the food-serving area beyond. As a consequence, we are subjected to the poor quality of air.

Our first approach to deal with this issue was to write a letter to Mr Tharwat Salem, director of food services, Royal Ontario Museum, March 26, 1993, a copy of which I submit. We received no response.

As a committee, we wrote of our concern to Mr Kenneth W. Harrigan, chair of the trustees, ROM, July 26, 1993, with a copy to Mr T. Salem. This too I submit. We received no response. We wrote again to Mr Harrigan, November 6, 1993, with a copy to the Honourable Ruth Grier, Minister of Health, and to Mr Salem; our third submission. We received no response.

On November 8, 1993, we wrote to the Honourable Anne Swarbrick, Minister of Culture, Tourism and Recreation, with copies to Ruth Grier, Kenneth Harrigan, Tharwat Salem and Elaine Ziembra, Minister of Citizenship, with responsibility for human rights, disability issues, seniors' issues and race relations. Anne Swarbrick responded to our letter December 10, 1993, and referred to our concern as a public health issue. She sent a copy of her letter to Kenneth Harrigan.

On November 6, 1993, we wrote to the Honourable Ruth Grier, with a copy to Elaine Ziembra, another submission. The Honourable Ruth Grier responded January 6, 1994. We submit total correspondence.

**Ms Bell:** Mr Chairman, members of the committee, I wish to express my concern with regard to a smoke-free environment in the Royal Ontario Museum cafeteria. I suffer from severe allergies and have experienced a great deal of respiratory distress when eating in the Royal Ontario Museum cafeteria.

It is my contention that those of us experiencing health problems caused by smoke in the cafeteria are being limited in our enjoyment of a publicly funded institution. It is for this reason that I wish to support this committee's submission for a smoke-free environment in museums, galleries and science centres. By not including these facilities in Bill 119, you will be allowing this inequitable situation to continue.

As a social worker, I protest the present process of exempting certain sites from legislation and by doing so

depriving me and others of our right to go to and be comfortable in publicly funded buildings.

**Mr Sylvain Smeets:** We all know that tobacco kills people. Be brave and be courageous. Take the necessary steps to encourage smokers to stop killing themselves. In particular, act to stop young people from taking up smoking.

For the past year and a half we have been going to the Royal Ontario Museum for Friday afternoon lectures. After our lectures we would go into the cafeteria. We would stay for about two and a half hours. They've got dinosaurs in the museum; we think they also have them in the cafeteria. Twenty per cent of the cafeteria is set aside for smokers. Last week we were there. After two and a half hours we had tears in our eyes because of the smoke. It is our contention that museums, art galleries and science centres should be entirely smoke-free.

Regarding section 9, paragraph 2, of the proposed act, which refers to educational institutions, given that a portion of the attendees at museums, art galleries and science centres are students whom we do not want to encourage to smoke, we urge you to amend section 9, paragraph 2, as follows: "A school, post-secondary educational institution, private vocational school, museum, art gallery and science centre." Thank you.

**Mr Biggs:** That is the end of our presentation. Thank you very much.

**The Chair:** Thank you. Just before going to questions, I just want to be clear. You don't work at the ROM, you're members of the ROM who go to different programs. Am I correct there, or are you also on staff?

**Mr Biggs:** No. We are not on staff, neither are we members, but we do attend U of T lectures there.

**The Chair:** That in no way takes away from your presentation, but I just wanted to be clear in terms of the title that we have down.

**Mr Biggs:** We thought we would prefer not to be members so that we would not be told we could use the fourth-floor cafeteria.

**The Chair:** Thanks very much. The parliamentary assistant had a couple of comments.

**Mr O'Connor:** First of all, I want to thank you for coming. My son, who will be 7 on his birthday this Saturday, is certainly a great fan of the ROM and refers to it as the dinosaur museum. I'm sure he'll be pleased that you've come today to make this presentation on behalf of him as a visitor and all the other visitors who do go to the ROM to enjoy the many different exhibits they have there, as well as to take an opportunity to sit down and have a lunch break in the cafeteria in a smoke-free setting.

I appreciate your coming. In fact what I will do on your behalf is undertake writing to the Ministry of Culture, Tourism and Recreation and try to get them to help us craft an amendment that we could put in for the regulations. That's what I can promise for you today.

I think what you presented here has certainly some good merit and I appreciate your coming to the committee and presenting a view for many people who have

visited there. I think probably the highlight for many grade school kids is a trip to the dinosaur museum.

**The Chair:** Did you want to comment on the parliamentary assistant's comments? I know that wasn't a question but I'm just giving you another shot.

**Mr Biggs:** No. I appreciate your efforts. Do you, Sylvain? Go ahead.

**Mr Smeets:** On section 9, paragraph 2, just change it.

**The Chair:** We hear you.

**Mr O'Connor:** Could I clarify? A lot of people who have been following the committee hearings will know this already, but for yourselves who are here today, in referring to the school, we've used the definition that is found in the Education Act, which goes beyond just the school proper; it includes the school yard and all the premises about. I think we do need to clarify that. I know that legal counsel probably doesn't like to spell it out any differently for lawyer reasons, but what we've heard from people has been that it needs to be spelled out somewhat differently.

I'm sure legal counsel have got the point themselves, because they've heard this said so many times. Thank you for helping me highlight that again for our counsel who will be helping us to draft changes and amendments.

**The Chair:** You should know that legal counsel is sitting in this room and listening to everything that is going on, so we'll see what happens. May we thank all four of you for coming before the committee this afternoon. We appreciate it.

ROY CAMERON

**The Chair:** Could I then call upon Dr Roy Cameron of the University of Waterloo, Centre for Applied Health Research. Dr Cameron, welcome to the committee. We have a copy of your presentation. Please go ahead.

**Dr Roy Cameron:** Thank you for the invitation to be here and thank you for putting forward this legislation.

What I'd like to do this afternoon is something that's quite focused. I've been involved in a number of research projects over the last 10 years pertaining to smoking prevention, smoking cessation, and some of the findings from a study that we're just completing now I thought might be pertinent to your deliberations, so I bring them forward.

The study that I have in mind is called the Community Intervention Trial for Smoking Cessation, commonly known as COMMIT. It's a study funded by the US National Cancer Institute at a cost of over US\$40 million. It's a large multicentred trial. A group of investigators from Waterloo and McMaster is the only Canadian team involved. We've been working in Brantford, Ontario, as our intervention community, and as part of that study we've done community surveys. Those surveys have resulted in some findings that surprised us. They may or may not surprise you, but I wanted to bring them to your attention.

The first part of the story that I'd like to present is the remarkable support we found among smokers for legislation that would set limits on smoking. There's a concern among smokers with two things: First of all, they want to

quit, and secondly, they don't want kids to start. I think those are the two conclusions that emerged from the data that I've presented.

You'll notice that baseline smoking rates in Brantford are high. They're higher than the provincial average; they're higher than the national average. Brantford is on the edge of tobacco country. I think a community located in that context provides kind of a conservative estimate of what the public thinks.

Randomly selected smokers and non-smokers were surveyed. As you can see, 81% of smokers indicate they'd like to quit. That's consistent with other surveys. They're not only saying they'd like to quit in a glib way over the phone, but over a period of approximately two years, 9% of all the smokers in Brantford, almost 1,900 people, signed up in a smokers' network, the intention of which was to support their efforts to quit. So people are serious about their interest in quitting smoking.

You can see that smokers in large numbers support a variety of non-smoking initiatives, particularly those targeted towards preventing youth from starting. Ninety-two per cent of smokers indicate that merchants should be fined for selling tobacco to minors; 74% agree that vending machines should be eliminated, kids shouldn't have access to them; 61% of smokers, and this really surprised me, agreed that the sale of tobacco products should be as strictly controlled as alcohol products. I was really quite surprised by that.

Skipping ahead, we found alarming data when we surveyed grade 9 kids in Brantford. It's clear that smoking is still attractive to youth, with 20% of grade 9 boys saying they smoked, 20% of grade 9 girls saying they smoked, 16% said they didn't smoke but they intended to start and 92% of the kids said it's easy to buy cigarettes.

We need this legislation. There's a lot of political support for it, I think, not only among non-smokers but among smokers as well.

I hope that you'll move ahead with this. If anything, I hope you'll make it more aggressive, and I hope that as we move ahead with this issue we avoid being divisive. The quarrel, I think, is not with the smokers; the smokers and the non-smokers, to a large extent, are on the same side on most of these issues. One way of looking at what we're doing is we're trying to create an environment where the large number of smokers who want to quit are more likely to be successful, an environment that supports non-smoking.

A specific suggestion that I have that's not in your legislation is that we shield from view tobacco products in stores. A very well-known way of promoting a product is to display it prominently at point-of-purchase, and in fact I gather that many companies pay a premium for shelf space in that area. Given that we ban the promotion of tobacco products, I'm not sure why we allow that particular form of promotion to continue. I think that kind of promotion hits people, for instance people who are quitting smoking, at a very vulnerable point. They see their favourite product right there in a situation where it's readily accessible. Why not cover it up?

I also highlighted support for banning of sales in



pharmacies, because in the press I gather this has been contentious. To my way of thinking, as somebody who's concerned with shaping youth attitudes around the smoking issue, it's nonsense to have cigarettes sold in a facility that's in the health business. That just doesn't make any sense. If we had doctors with cigarette vending machines in their waiting rooms saying that they needed to supplement their income because they're in an under-populated area—I can see the smiles around the table; the absurdity is clear. I agree with the speaker one or two ahead of me, who said: "You've got to make up your mind: You're a business person or you're a health care professional. Choose."

That's the end of my remarks.

**Mrs O'Neill:** I am very happy you brought the statistics in. It seems to be a recent piece of research, which I think is very helpful.

I think you're the first one who, at least with some statistics, has indicated that smokers and non-smokers have very much the same goal, particularly regarding young people. Could you say a little bit more about creating an environment that supports smokers who want to quit?

**Dr Cameron:** Sure. I think that smokers who want to quit really get into trouble and relapse under circumstances where other people are smoking, so I think the more they're exposed to people smoking in public situations, the more difficult it is for them to resist urges. They're more likely to have urges to smoke under those circumstances.

It's like most of us find it difficult not to eat when other people are eating. None of us is probably having a problem being tempted to eat at this moment, because there's no food in the room. It's easy. If there was good food available, we'd probably be packing it in whether we're hungry or not. I think that's essentially the phenomenon that we're dealing with. The more we can put smoking into the background, so that people are not only not exposed to smoke but they're not exposed to people modelling smoking, the more supportive the environment is going to be, I believe, towards smokers who are trying to quit.

**Mrs O'Neill:** Did your research look at all at contraband?

**Dr Cameron:** No.

**Mrs O'Neill:** Do you want to make any comments about that?

**Dr Cameron:** Well, it's a complicated problem. I spent a lot of hours writing letters and losing sleep when this legislation was working its way through. When I thought about this, it seemed to me the fundamental problem is this: There are huge bucks to be made in selling tobacco—big, big bucks—and as long as there are big, big bucks to be made in selling tobacco, there are going to be vested interests who have an incentive to work against public health. It seems to me the way out is to strip the profits out of those companies, just absolutely take the money away. We need a legal source of cigarettes as long as we've got smokers smoking, but why should people make hundreds of millions of dollars on a

product that's killing 38,000 a year in this country? Does that make any sense to you? It doesn't make any sense to me.

**1610**

I saw numbers in the paper indicating that there were 2,400 people employed in the four plants that manufacture cigarettes in Canada. That works out to nearly 16 deaths a year per job. Why do we put up with that? Does that make any sense to you? There are 1,000 tobacco farmers in this province, 13,000 deaths: 13 deaths per farmer per year.

**Mrs Caplan:** I found your presentation very interesting. Also, we have on our desk an article on preventing teenage tobacco addiction. In it, it recommends a model for school policies on tobacco, and I was wondering whether you were aware of any schools or school boards in Ontario that have anti-smoking or anti-tobacco-use policies in their schools or require them.

**Dr Cameron:** We're actually doing a study with 6,000 students now across seven boards in Ontario. We started working with these kids when they were in grade 6. They're now in grade 10.

I can tell you that it's really hard to work with kids in high schools. All this talk about educational approaches, I think, rings hollow, because when kids are that age and they're smoking to rebel, I'm really concerned that there's the potential for doing as much harm as good.

I don't think there are easy solutions. I think this is a community problem. I think we've got to reach the point where smoking is just stupid. It's not cool; it's stupid. Smoking is about as fashionable as wearing a green polyester leisure suit. When we get to that point, I think kids will quit.

**The Chair:** Mr Wiseman is not wearing a polyester suit, and he has the next question.

**Mrs Haslam:** Besides, his is blue.

**Mr Wiseman:** No, mine would be green. Mine's most likely to be green.

**Dr Cameron:** I said that because I own such a suit.

**Mr Wiseman:** I've spent a lot of time with young people. Before my life here I was a high-school teacher.

**Mrs Haslam:** You have a life here?

**Mr Wiseman:** This is a life, yes. I'm interested in your comments where you say that 16% of the kids in grade 9 are thinking about smoking, that 26% of the young women are smoking now and 20% of the young boys. When you did this survey, did they tell you at any point what was the trigger mechanism that got them to start the first time? Do you have any idea of what that is, and if you do, if there's anything they told you?

We've heard from a number of groups of young people. Some of them said that they'd like to quit now but they can't; they're hooked. Some cessation activities in the school were suggested, and even peer pressure is important. So I've asked if anybody has taken teenage youngsters who want to quit and get them into the elementary schools to say, "Look, guys, this isn't as cool as it looks."

**Dr Cameron:** What we've found in our data is that

you can predict kids who are at risk. They're at risk if their parents smoke, they're at risk if they've got older siblings who smoke, they're at risk if their friends smoke. This is a very interesting one: They're at risk if they're in school. If they're a non-smoking kid in grade 6 and they're in a school where there is a high smoking rate in grade 8, they're at risk. They imitate older kids. They're at risk if they're in a school where the teachers and the principal smoke. So we're influenced by what we see around us. That's a major determining factor. Kids imitate older kids; kids imitate adults they look up to.

Another factor is disposable income. The more money a kid has in his pocket, the more likely that kid is to get into smoking. That's why I'm really concerned about the legislation that lowers the price of cigarettes. I think it's a real problem, and I don't think all the educational programs in the world are going to offset the damage that's done.

I was going to say, I'm just about out of time.

**Mr O'Connor:** First of all, I want to thank you for coming. I have had an opportunity to sit and talk about some different ways of involving people in the community in the whole tobacco strategy. The government alone can't do it. Maybe you could share with the committee the strategy. The COMMIT program also looked at some other jurisdictions within the United States, did it not? I wondered if the numbers were comparable. You might want to share that with the committee.

**Dr Cameron:** I agree with you about the federal tax, absolutely. But it's difficult for me to make a comparison because I don't have all the numbers in my head. In general, Canadian smoking rates are lower than smoking rates in most of the states, excluding California, and attitudes towards non-smoking are stronger here. There's more public support for non-smoking in Canada. Those are very broad generalizations.

**Mr O'Connor:** Does the US price affect that?

**Dr Cameron:** I'm sure it does. It would be a strange aberration of economic law if doubling or tripling the price had no impact at all on consumption. There are lots of data that show a relationship.

My final statement, I'm now speaking very personally; I don't want to become sentimental, but I do want to put a personal face on this. When I was 16 years old, I came home one night and I found the body of my 49-year-old father. He had died suddenly, unexpectedly. He was a heavy-duty smoker of Player's cigarettes, the folks who still put the racing billboards up. He left a 44-year-old wife. He left four children who ranged in age from 10 to 16. We had no income.

I find myself wondering how many families are on welfare because of this pernicious habit; I really do. I'll just leave it to your imagination to figure out what this does to families. It is not a pretty picture. Somehow we need to get beyond the statistics and put a human face on this. This is not a glamorous product.

**The Chair:** On behalf of the committee, thank you very much, Dr Cameron, for your submission and also for your personal testimony. We appreciate your presentation very much.

#### CANADIAN CANCER SOCIETY. ONTARIO SOUTH CENTRAL REGION

**Ms Patricia Wise:** Thank you for this opportunity to submit our brief to the committee on Bill 119 on behalf of the Canadian Cancer Society. Attending with me is Karen Poshtar, our tobacco reduction chairperson in the city of Mississauga.

In my capacity today, I'm past president of the unit in Mississauga and also presently on the board of the south central region, which as you can see from our report takes in quite a sizeable district. I'm sure everyone is very aware of where the cancer society has been on this issue.

The Mississauga unit of the Canadian Cancer Society, for those who may not be aware, serves the ninth-largest city in Canada. As volunteers, we are very committed to providing the public with information on tobacco risk and supporting education programs targeted to our children. Of course, there are many well-founded reasons for reducing tobacco, but our high priority is that we reduce the burden of cancer and other tobacco-related diseases.

We must be very thorough about our education with the teenagers, because truly they don't perceive the threat of illness. They're really following peer pressure, and it's not going to happen to them. Of course I think we're all very familiar with teenagers' approach to anything that could potentially endanger their lives. I've outlined some facts here, and I am sure that I am really just reiterating what has been published in many publications prior to my arriving here.

1620

Tobacco, of course, is a major contributor to approximately 30% of all cancers, including 85% of lung cancer. I just lost my own father to lung cancer. He really didn't smoke until he joined the navy. Of course, during the war that was a major pastime; cigarettes were very cheap. It was some years later that my father quit smoking, but he still died just two years ago of lung cancer. I also have a husband who has a respiratory problem and has to avoid all places with smoke available to him. He doesn't have a choice in this, and of course it is our choice to not go where there is smoke because of his failing health.

The figure of 38,000 Canadians who die per year of tobacco-related diseases is staggering. I don't think many of us realize just how many of these people are young people. Everybody always attributes cancer to that certain age, but being in the cancer society, we unfortunately see far too many people under the age of 25 dying of cancer. In Ontario alone, one person every 40 minutes dies of cancer, which has got to be staggering to anybody.

There is a rise of young women smoking. Why, we don't know. Maybe they're just frustrated, I don't know, but they are on the rise. At the moment we note that there are about 32% men and 29% women who smoke.

Tobacco also kills nine times more people than traffic accidents and 101 times more people than fires. I always say there are always laws in place to enforce a penalty for a violation, but I don't believe a law has been written yet where it says, "You can't get cancer." There isn't a dime on earth that you could have that's going to protect



you with a clean bill of health, and I think that's the bottom line of what law enforcement can do. Really, when I hear all of the media on the objections of smuggling and taxes and everything, I would like to just say to these people in power: "For crying out loud, come back and let's look at what the real issue is. We've got a major concern here. You can hire all the people you want to enforce your laws. You tell me how many people can enforce the law of a clean bill of health."

Some personal experiences that are very scary: For your information, we've attached some letters here from our schools, which Karen will speak to. But in addition to that, a number of our small convenience stores in a lot of Toronto areas are known to be selling single cigarettes over the counter, and to children, whatever age they may be: 10, 11 and up, it doesn't matter. In one of these cases, I witnessed a store owner selling to a minor and I said, "Why did you sell that child a cigarette?" The store owner replied, "Because he can't afford a package." It just sickened me. As a cancer society volunteer and a citizen with a concern for our upcoming generation, that sickens me. We urge our government to enforce Bill 119, the reduction of tobacco products to minors. The increasing of the age to 19 will help. Proper identification is definitely a must, and penalties for violation have got to be enforced.

Our recommendations are clearly stated out here. We have a strong agreement with what Bill 119 contains and the components that are essential to our concerns. Please reduce the age and the accessibility. Get those vending machines out. Enforce areas where smoking can't be maintained, of course always thinking of the areas where children are primarily found, and have strong penalties for non-compliance.

I would like to just reiterate that the volunteers of the Canadian Cancer Society appeal to the government to take a significant legislative step towards the eradication of tobacco-related diseases in our province. Collectively, by ensuring that this legislation is proclaimed and enforced, we will win the devastating war on cancer, in particular by altering tobacco use at an early age.

Our mission is to eradicate cancer. Our volunteers give their time and their money to ensure the hope for a cancer-free future. Why would we go backwards now, undoing all the gains we have achieved? I really have to emphasize that. I've been a cancer society volunteer for 11-plus years. During that time, I have not missed a beat with ensuring public information, raising money for much-needed research, having setback after setback, watching friends and family die. I just want it to stop. We have a mandate that will not allow for setbacks and we urge you as a committee to please support our work, save lives and ensure a quality living environment for our future.

I would like to ask Karen now to express a few comments about her work in the schools. She works directly with the children.

**Ms Karen Poshtar:** Education is a great idea. I think the education has worked to the point that I go into classrooms—and I've done over 750 children in different classrooms for the Peel Board of Education this year,

since January—and they know the answers to the questions. They know that there are 3,000 cancer-causing ingredients in cigarettes. They know that their lungs are going to turn grey, their fingers are going to yellow. They know that it's bad for their heart and lungs. The answers come fast. There's no thinking about it. They've had the information; they know about it; they've seen the commercials.

But somehow, between grades 3 and 6, they get real stupid. The same grades 7 and 8 children that I do the presentations to know the answers too, but on the way out of the cafeteria or out of the parking lot after lunch, you see them. They wait till they're off the school property, but they've got their cigarettes and they're smoking. It's a very frustrating experience for the phys-ed teacher who talks about the students she's had on her teams and she's worked with for all of grades 6, 7 and 8. One in particular drives by the high school and she said, "Every year it's the same story: My star athletes are standing outside the high school smoking cigarettes."

Where do they get access to cigarettes? They don't perceive it to be illegal. They know that it's bad for them but they continue to smoke cigarettes. I think that legislation has got to take over from education. Unfortunately, one of the problems that you're going to face with even legislation is that their peers are the ones who sell them the cigarettes. There isn't a corner store or pharmacy or gas bar that doesn't have a youth working there after hours. Even in a store that's run by someone who is dedicated to not selling cigarettes to the children, when the owner goes home for his dinner, the student who takes over is willing to sell cigarettes to his friends. They have the ready access to them. The idea of having it similar to our local liquor control board for cigarettes is very appealing, because it's much more difficult, I think, for youth to get at them that way.

I just can't tell you that there's anything else we can do. We've done the education. They know the answers to the questions. We've got to eliminate the availability through vending machines and corner stores and pharmacies.

**Mr O'Connor:** I want to thank you for coming and making this presentation. We've heard from a lot of groups, particularly groups like the Canadian Cancer Society and the Lung Association. We've got one of their little placards here.

We're all part of the overall strategy, so I appreciate you coming, because, yes, the government has to do the legislative end. We also need to support the people in the community who are doing a lot of hard work for us. Legislation alone can't do it all; there's got to be many different focuses on this strategy.

I think it's an achievable strategy. I don't think it's something that we should give up on. I know that with the dedication that you've shown us here today, we've got a lot of support out there in moving forward with this.

So I appreciate you coming and making this presentation and keeping up the fight and allowing us the opportunity, because part of the education process will also be through even the committee hearings. There's a lot of

people watching, and pointing out and putting a lot of different views forward is important.

1630

The letters from the students in the back really hit the point, because some of the kids, you can get to. I don't know about—you say there's a point where they turn stupid. Well, I saw a great poster, and I don't know who put it out—it might have been the cancer society—but it showed a hockey stick, it showed a bread stick and I think a stick of gum or something. Then it showed a cigarette and called it a stupid stick. So I think there are a lot of different approaches that we've got to take to this, and I appreciate you coming forward.

**The Chair:** Thank you very much for coming before the committee today. We appreciate it.

#### ALLERGY/ASTHMA INFORMATION ASSOCIATION

**The Chair:** If I could then call on Ms Susan Daglish. Welcome to the committee. We have a copy of your submission from the Allergy/Asthma Information Association. Please go ahead with your presentation.

**Ms Susan Daglish:** Thank you. When fibre optics first became available, we had a speaker who showed us a picture that was taken of the lungs by fibre optics. It showed an asthmatic's lungs, and that picture showed lungs that were so red and so raw and so sore-looking that everyone in the audience gasped. The doctor then went on to say that those lungs weren't really the worst. The person who had those lungs didn't even feel symptoms. That was mild asthma. So if those lungs look so red and raw, we know that people with asthma—people with allergies have the same problem in their nasal system—have very inflamed, very sore lungs. What happens when they're exposed to tobacco is that it's terribly irritating for that inflammation. It's a little like rubbing salt into a wound.

We know that asthma is a huge problem. We know that there are 10 asthma deaths a week and that the incidence of allergy and asthma is increasing each decade by 25%. So there are a lot of us out there who have a lot of problem being exposed to tobacco smoke. To us, having to be around tobacco smoke is a barrier. We are considered to be physically disabled.

The organization I represent is celebrating 30 years. We began as an organization that recognized a need for food labelling. We achieved it. We also recognized that tobacco was a big problem for us. We were very, very much confined to what we could do, where we could go, because tobacco was so open.

In the early 1970s one of our members called a meeting. She invited the Allergy/Asthma Information Association, any organization like cancer, lung, physicians' and nurses' groups, anybody she could think of who might be interested in doing something about the tobacco problem. Most groups didn't even show up to that meeting. One person did, Gar Mahood, and he had the vision to see that this was a problem and that it probably could be licked. He carried on and founded the Non-Smokers' Rights Association from that.

We were very, very high at that meeting. I can remember. I can remember we said things like, "The ashtray

will go the way of the spittoon," that smoking would only be done in private by consenting adults. We had a lot of things we thought about. I don't think any of us would have believed 20 years ago that we could have come so far as we have in 20 years. In some ways it doesn't seem far, but in other ways we have come a long, long way.

To me, this Bill 119 is kind of a real step forward. I think it's just great. I want to come here and support that bill and to tell you that it is something that has to happen, especially in the light of the last few days.

We do feel that perhaps our prime concern, that tobacco acts as a barrier to our access to public places, could be tightened up. We would really like to see smoking banned in all public places. As the people from the cancer society said, it has to be legislated over a broader aspect. Right now a municipality can say, "We'll allow smoking here, but we won't allow it there." I think it has to be a provincial mandate, that we just say, "There isn't smoking allowed in public places." I think it's good for the health of everyone, but particularly people with asthma and allergy.

That's what I really wanted to come and tell you today, to urge you to think very seriously about this issue of smoking in public places and how it acts as a barrier to one in five people who live in Ontario.

Are there any questions you would like to ask me?

**Mrs Caplan:** Thank you for an excellent presentation. We've been discussing the idea of municipal licensing. There have been a number of suggestions made. One was the notion of a government monopoly like the LCBO and other considerations. A possible model would be as you have in Metropolitan Toronto. They license taxis and restaurants and that sort of thing on a user-pay so it won't cost the taxpayers any money. Has your group thought about municipal licensing or some kind of a licensing option to help the control of access to tobacco?

**Ms Daglish:** Actually, it's funny you mention that, Ms Caplan. We had often said that we thought it would be an excellent idea if cigarettes were sold through the LCBO simply because they seem to be in the best position to check for identification of age. Because they do such an excellent job of controlling underage problems with drinking, we felt that they could certainly do it with smoking. It's so terribly important that children be kept from cigarettes. That's just a key issue.

**Mrs Caplan:** We've heard that over and over, how important primary prevention, particularly of young children and youth, is. Had your group considered the kind of suggestions for policies in the schools around this issue? We've heard some are effective, some are not. Have you thought at all about that?

**Ms Daglish:** I know that my daughter, who is a severe asthmatic, which got me into it, said that she developed very, very good bladder control because she could not go into the washroom at her school.

**Mrs Caplan:** My goodness. Oh, dear.

**Ms Daglish:** I really feel very strongly that there should not be smoking—

**Mrs Caplan:** Permitted.



**Ms Daglish:** —permitted in the school by staff or students, because we know that in the junior schools the children have trouble with the tobacco smoke in the environment from the staff room. We would certainly applaud any effort to get it out of that work area as well.

**Mrs Caplan:** I'm assuming you'd also like to see an amendment in the legislation that banned kiddie packs of cigarettes entirely?

**Mr Wiseman:** Those are irrelevant now.

**Ms Daglish:** It is, isn't it. Yes, I would. I understand that in some places they have even been known to break open tobacco packs and sell them singly or in threes.

**Mrs Caplan:** Perhaps a ban that would not permit the sale of individual cigarettes?

**Ms Daglish:** I don't know how you could do that. I think there probably is one, but I think if the age barrier was controlled, that would eliminate that problem.

1640

**Mr Wiseman:** You raised an interesting question about not allowing anybody to smoke in the school, and I'm just wondering how you would do that, given that there is already a widespread addiction among staff and among senior students.

**Ms Daglish:** It is difficult. I must share with you people an interesting story. About this time last year I was in Ottawa and I was going to Tunney's Pasture for a meeting. The taxi driver took me along. Of course, there's no smoking allowed in the federal buildings, and so the people who were wanting to smoke were standing out in the doorways having their smoke. I said to the taxi driver, "My, they must be really addicted to want to stand out in this kind of weather and have their smoke." He said, "Actually, about three days ago I had a visitor from Europe in my cab, taking him to a meeting in Tunney's Pasture, and as we went along the visitor said, 'All these office buildings are government buildings, aren't they?'" The taxi driver said, "Oh, yes." The visitor from Europe said, "You know, I'm surprised that the government allows so many prostitutes to hang around outside."

I'd be concerned about schools because there is the addiction. I think there would have to be some sort of place where staff could smoke that was ventilated adequately so that the children were not exposed. I would not like to see teachers hanging about outside the buildings having their smoke. I don't think it would send the message that we want to our children.

**The Chair:** Thank you very much for coming before the committee this afternoon. We appreciate it.

BRUCE GITELMAN

**Mr Bruce Gitelman:** This is the first time I've been in the Legislative Building. I am very impressed with the schedule that you have undertaken today and appreciate that you're willing to listen to all these groups. I'm sure their input has been helpful in getting ready for this bill.

As a concerned citizen, I wish to comment on Bill 119. I strongly urge all committee members to do whatever they can to promote the passing of Bill 119, as you can personally help to alleviate a great deal of human suffering and death.

My story begins with a trip to the old neighbourhood. I remember many years ago as a child when an old, decrepit store was demolished and a modern, gleaming white Shoppers Drug Mart—a division of Imasco, manufacturer and purveyor of deadly tobacco products—was erected on the site.

I fondly remember my trips to the new emporium of delights. No, I was not a drug addict, but simply a normal six-year-old child who knew a good thing when I saw it. You see, when my mother and I went to the Shoppers Drug Mart to buy medicine to make us healthy, I discovered the pleasure pyramid at the checkout counter. You know what I mean? Why, of course, the candy counter. You see, the pushers—or marketers—at Shoppers Drug Mart were very smart. Just next to the cash register, at kids' eye level and within easy reach, they had placed the candy counter. I was pie-eyed looking up at a glorious mountain of brightly covered and well-lit candy packages in their shiny foil wrappers. About as far as I could see, just beyond the candy, at the top of the mountain was a smiling cashier-pharmacist with a professional-looking white lab coat.

It was not until many years later when I got taller and after a few cavities that I noticed that the real treats were near the top of the pyramid. Those brightly coloured, well-lit packages with their shiny foil wrappers being sold by the smiling cashier-pharmacist were nothing else but deadly tobacco products. Those same people whom we had trusted all those years for excellent advice on health care products and delicious treats were just supplying one more treat for those adults who were addicted to tobacco.

While the candy had special contests for exciting kids' toys or promised bursting flavour, the tobacco products held even greater promise. Everywhere you looked in the city, from first-class sporting events to the finest shows and culture, the tobacco brand names were there to celebrate them with you.

This story does not have a happy ending. Many years later when I had to visit the old neighbourhood Shoppers Drug Mart where my mother bought her cigarettes, it was still gleaming white and well maintained with tobacco profits from human suffering. In a reversal of roles, instead of my mother taking me to the drugstore for medicine, I was going to get the drugs she needed to make her happy. The final product at the top of the Shoppers Drug Mart product pyramid was the morphine that my mother needed to kill the pain from the cancer that was killing her. Only this time the package was not bright or shiny, but dark and brown like all narcotics should be marked.

Bill 119 is very important because it will take the tobacco products out of the drugstore and identify or package them like the really dangerous narcotics that they are.

Don't let the tobacco companies hoodwink you. They will tell you many things, but do not listen. They will tell you that generic packaging will confiscate their valuable brand names. This is only fair, given the number of lives their products have confiscated.

The tobacco companies will tell you that tobacco does not cause cancer. Do not believe them. My mother died

of pancreatic cancer. I spent many days in medical libraries researching the world's databases looking for a cure. Pancreatic cancer is terminal. There is no cure. Pancreatic cancer consistently appears in higher levels in countries where there are high levels of smoking. All of the epidemiological studies that I have read linked it to tobacco. The one fact that I found most disturbing was a report in the late 1800s written by a doctor in the respected British medical journal the *Lancet* which reported that pancreatic cancer did not appear in Britain until after the introduction of tobacco.

This is 1994 and it is about time that we stand up to the powerful tobacco lobby and stop the suffering.

**Mr Tony Rizzo (Oakwood):** Thank you for your appearance here. I understand that the British government stopped pharmacists from selling tobacco around 1987. It is very revealing that connections were made between pancreatic cancer and smoking over a century ago in England. Do you have any figures of the results since 1987 in England, after the legislation was changed?

**Mr Gitelman:** To be honest, I'm not aware of what happened in England, but I know that it takes many different things to reduce the amount of smoking. I understand we've been very successful in Ontario. I would hope that any steps that we can take in Ontario similar to England and elsewhere will be taken.

**Mr Martin:** You reference in your presentation in a couple of places this powerful tobacco lobby that seems to have control, and certainly in the last few days we've seen just how much power and control it does in fact have. They've created a situation where now we as a government find ourselves on the horns of a dilemma, pushed into a corner, taking what I feel is the high road, making the right decision, but ultimately, will we be able to maintain that position in light of the discussion that is now happening out there?

Do you have any suggestions for us, any encouraging words, any ideas, any thoughts that might be helpful in front of that at this point in time?

**Mr Gitelman:** I can appreciate the stress that the Ontario government must be under right now with the recent changes. All I can say is to stick with what you're doing, and that is to continue to pass legislation that makes it more and more difficult for these products to get out in the marketplace. Label them for what they really are and try to get them away from places where children can start using them. I just wish you all the best in continuing to do that.

**The Chair:** Thank you for coming and for your personal presentation. We appreciate it.

#### CITY OF YORK BOARD OF HEALTH

**The Chair:** Our final witness today is from the city of York board of health. Welcome to the committee.

**Dr Rosana Pellizzari:** Good afternoon. My name is Dr Rosana Pellizzari. I am a family doctor. I work in a community health centre in the city of Toronto called Davenport Perth Community Health Centre. I am a member of the board of health for the city of York. Unfortunately, the chair of our board, Councillor Joe Mihevic, is out of the country and wasn't able to join me

today. I'm going to be reading to you my brief, which you, I believe, have copies of.

The recommendation we bring to you is that the Tobacco Control Act is a necessary and effective component of a strategy to reduce tobacco consumption in the province of Ontario. Compliance and enforcement are crucial. The board of health for the city of York applauds and supports the government and urges consideration of more effective means of enforcement such as compulsory licensure for retail sales.

#### 1650

Tobacco kills over 13,000 people in Ontario every year. Smoking among grade 7 students has increased 50% since 1991. In Ontario, smoking accounts for one in five preventable deaths. These are not new statistics to you. Whether we are active smokers or exposed to tobacco smoke in our homes, workplaces or environment, we are aging, we are sick and dying. This is the legacy of tobacco consumption. This is why we, as a board of health, are concerned that government introduce policy which will secure and protect a healthier future for all Ontarians. This is why we support Bill 119, especially and maybe in spite of the federal government's actions this week, which undermine any provincial attempt to reduce consumption.

Cigarette smoking in Canada has shifted significantly, both socially and demographically. The city of York represents those trends. Men and women in the lowest education group—less than high school diploma—have greater rates of smoking. Our city is culturally diverse with newcomers coming from countries with a high prevalence of smoking. In addition, some groups have shown less of a decline in smoking rates, particularly women less than men, girls less than boys, unemployed less than those with jobs and low-income people less than high-income Canadians. Welcome to the city of York.

Canada's tobacco control policies are among the best in the world. As health care providers, we are dependent on our legislators to create strong disincentives for smoking. It is within this greater context that our work becomes meaningful. Research indicates that counselling and education have limited effectiveness in prevention and cessation. In order to achieve true tobacco reduction, we need Bill 119 to reduce access, to reduce exposure and to strengthen enforcement, particularly to new smokers: the youth of this province.

What we applaud is the commitment of the government to move beyond taxation, to address access by prohibiting the sale of tobacco to youth under 19 years of age, by banning the sale of tobacco in health facilities, including pharmacies, and by banning tobacco vending machines.

We hope it will be the intent of this government to use section 5 to introduce generic packaging of cigarettes. We must do everything possible to dissipate the glamour and brand-name recognition of tobacco products, especially for young consumers.

We are pleased that the act includes the prohibition of smoking in certain places. This reinforces and supports work being done in several municipalities, including our



own, to restrict exposure to tobacco smoke.

We hope that enforcement of the act will be possible and effective. Although fines and bans have been outlined, a system requiring the renewal of a vendor's licence would make enforcement much more conducive. Such a system could be implemented at the municipal level.

The board of health for the city of York has gone on record in support of Bill 119. We do not want to see the act diluted. On the contrary, we want reassurances that the act will be enforced. We congratulate this government's effort to go beyond the rhetoric of the health goals for Ontario into effective action.

**Mr O'Connor:** Thank you for your strong presentation. I have to agree with you that in light of the recent changes in Ottawa by the Liberal government, I'm quite disheartened by those moves. It really seems to undermine a lot of what we're trying to do here and the overall strategy that has been in place by legislators for a long time.

It annoys me, the fact that Mr Clinton and Mr Chrétien can go on the telephone and make decisions to have air strikes, yet at the same time we've got 40,000 Canadians across this country dying annually and they can't make a phone call and say: "Look, we got a smuggling problem. Let's try to work something out." I'm really annoyed by that.

Anyway, to get to your submission, do you have any experiences around the licensing system? You're part of Metro. Does Metro not have that and can you share some of your experiences with us?

**Dr Pellizzari:** As a member of the board of health, we discussed licensing as one strategy, in that, if in order to sell tobacco products you had to be licensed, you could then enforce certain criteria or you could withhold licences for people who had actually not complied with the act.

Not being a politician and not being involved within the municipality at that level, I can't comment on what exists in Metro. I know that we, as a board of health, were very interested in pursuing that as a possibility to strengthen the act.

**Mr Eddy:** Thank you for your presentation and helpful suggestions and especially that you want us to go beyond the rhetoric of the health codes for Ontario and do something. I had expected maybe you'd offer some suggestions for even more effective and tougher legislation. Maybe you'd want to comment on that.

I'm not by nature argumentative, but there is a statement on page 3 that I wanted to ask you about. You said, "Canada's tobacco control policies are among the best in the world." My view is that they're the very worst.

We've seen a past federal government and a provincial government absolutely ignore the contraband tobacco situation to the point that the OPP says it's nothing to do with them; the RCMP says it's nothing to do with them. I've seen it grow and it's in my riding, so I know how—to the point where the other day there was a release that one out of every two cigarettes smoked in Metro is contraband. It horrified me that it was to that extent.

So what did you mean by that sentence? Would you mind, because it was going to bother me if I don't ask you.

**Dr Pellizzari:** Sure. What I was referring to was the taxation of tobacco products—

**Mr Eddy:** Oh, I see.

**Dr Pellizzari:** —because we know that consumption is linked to cost and that every time you increase the cost of a package of cigarettes, you do—especially with the young, who are more price-sensitive. However, it also includes the prohibition of smoking in public places, in workplaces. We have some of the more progressive types of policy around exposure and access through taxation in the world.

**Mr Eddy:** They're not quite enough, though, but they're good.

**Dr Pellizzari:** Obviously, no, they're not.

**Mr Wiseman:** My concern is enforcement and how to make sure that vendors and people don't distribute the necessary four cigarettes to get a child addicted. That's something I would like you to comment on, because you do mention enforcement, but I think we need a little bit more in terms of what we should be doing and what we could try to do.

**Dr Pellizzari:** I think whenever you have law, then of course you need policing of that law. Do you mean what kind of auditing or monitoring you would need in order to make sure that vendors were complying?

**Mr Wiseman:** Yes.

**Dr Pellizzari:** You need to put the human resources into that, of course. That's why if you had some kind of licensing, even with a nominal fee, you might be able to cover some of your costs of actually having inspection to see whether people were complying with the regulations of that licence.

**Mr Wiseman:** Would you see a greater role for the health units in making sure that retailers and people who are selling cigarettes would comply with that?

**Dr Pellizzari:** Again, at least in the city of York, it has boiled down to the problem of human resources. Historically, public health boards have not been the beneficiaries of large pockets of money in this province. We have been a sector of the health system which has been, some would say, underfunded, so we don't have a lot of human resources.

However, municipally, we do have public work inspectors. We have other staff municipally that we could use. We're currently using health inspectors now to enforce some heating bylaws in the city of York. In fact, if we had more health resources, those people could be freed up to do some of the enforcement around something like this. I think this is an area where municipalities can play a role.

**The Chair:** Thank you very much, Doctor, for coming before the committee this afternoon.

Members of the committee, we will gather again in Thunder Bay on Monday and be back here Tuesday morning at 10 o'clock.

The committee adjourned at 1700.







## STANDING COMMITTEE ON SOCIAL DEVELOPMENT

- \***Chair / Président:** Beer, Charles (York-Mackenzie L)
- \***Vice-Chair / Vice-Président:** Eddy, Ron (Brant-Haldimand L)
  - Carter, Jenny (Peterborough ND)
- \*Cunningham, Dianne (London North/-Nord PC)
  - Hope, Randy R. (Chatham-Kent ND)
- \*Martin, Tony (Sault Ste Marie ND)
  - McGuinty, Dalton (Ottawa South/-Sud L)
- \*O'Connor, Larry (Durham-York ND)
- \*O'Neill, Yvonne (Ottawa-Rideau L)
  - Owens, Stephen (Scarborough Centre ND)
- \*Rizzo, Tony (Oakwood ND)
- \*Wilson, Jim (Simcoe West/-Ouest PC)

*\*In attendance / présents*

### **Substitutions present / Membres remplaçants présents:**

Caplan, Elinor (Orléans L) for Mr McGuinty  
Dadamo, George (Windsor-Sandwich ND) for Mr Hope  
Haslam, Karen (Perth ND) for Ms Carter  
Wiseman, Jim (Durham West/-Ouest ND) for Mr Owens

### **Also taking part / Autres participants et participantes:**

O'Connor, Larry, parliamentary assistant to the Minister of Health

**Clerk / Greffier:** Arnott, Doug

### **Staff / Personnel:**

Boucher, Joanne, research officer, Legislative Research Service  
Gardner, Dr Bob, assistant director, Legislative Research Service



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## Legislative Assembly of Ontario

Third Session, 35th Parliament

## Assemblée législative de l'Ontario

Troisième session, 35<sup>e</sup> législature

# Official Report of Debates (Hansard)

Monday 14 February 1994

# Journal des débats (Hansard)

Lundi 14 février 1994

## Standing committee on social development

Tobacco Control Act, 1993

## Comité permanent des affaires sociales

Loi de 1993 sur la réglementation  
de l'usage du tabac

Chair: Charles Beer  
Clerk: Doug Arnott



Président : Charles Beer  
Greffier : Doug Arnott





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## STANDING COMMITTEE ON SOCIAL DEVELOPMENT

Monday 14 February 1994

The committee met at 0905 in the Valhalla Inn, Thunder Bay.

## TOBACCO CONTROL ACT, 1993

LOI DE 1993 SUR LA RÉGLEMENTATION  
DE L'USAGE DU TABAC

Consideration of Bill 119, An Act to prevent the Provision of Tobacco to Young Persons and to Regulate its Sale and Use by Others / Projet de loi 119, Loi visant à empêcher la fourniture de tabac aux jeunes et à en réglementer la vente et l'usage par les autres.

**The Chair (Mr Charles Beer):** Good morning, ladies and gentlemen. The standing committee on social development is in session. We are meeting today to consider Bill 119, An Act to prevent the Provision of Tobacco to Young Persons and to Regulate its Sale and Use by Others.

May I say first of all that we're all delighted to be here in Thunder Bay, especially to be in a room that has this gorgeous view. Those of you seated in the audience can't see, but I assume you see it every day so you won't mind if our eyes seem to wander a little from time to time. Perhaps I should make at least one reference to the fact that it's Valentine's Day and hope that peace, love, compassion and harmony will guide the deliberations of the committee as we listen to the testimony today.

LAKEHEAD BOARD OF EDUCATION  
SECONDARY SCHOOL PRINCIPALS AND  
VICE-PRINCIPALS ASSOCIATION

**The Chair:** We have a very full schedule, so we will start with the Lakehead secondary school administrators association, Mr Brian McKinnon.

**Mr Brian McKinnon:** I'm pleased to be here. As you can see from my report, the Lakehead Board of Education Secondary School Principals and Vice-Principals Association gives its unbridled support to Bill 119. We're very pleased that it is in the process of being made into law, we hope. That is one of the reasons I am here to represent our association.

The report, which is succinct, essentially says what probably you all know anyway. We deal with teenagers who are ages 13 to 19. That's a very vulnerable group. We are very concerned about the availability of cigarettes to this group. We do what we can to teach them good, healthy lifestyles, try whatever we can in our health classes and other curricula, but it's increasingly difficult when these same students can leave the school at 3:30 or at noonhour, go across to the corner store, at the age of 13, 14 and 15, and purchase cigarettes.

As I've indicated in the report, the irony is not lost on us. We do what we can within the school walls, but I'm afraid we don't feel there's a lot of support outside of those walls. We are soliciting all of you at these tables to support us in our fight, and we will continue within the walls to try to get this legislation passed. We fully support your efforts in this and we applaud the NDP

government in its efforts.

That is a résumé of the report. If there are any questions, I'd be pleased to field them at this time.

**Mr Dalton McGuinty (Ottawa South):** I appreciated your comments, especially about teenagers viewing themselves as somehow immortal. We met a medical officer of health in North Bay who told us it was her opinion that teenagers found themselves to be infertile, immune, invulnerable and immortal, and that's probably based on a great deal of truth.

One of the concerns we have is that teenagers or young people will still on occasion be able to obtain cigarettes elsewhere than your usual retailer, coupled with the fact that Bill 119 is going to address the problem of smoking in school yards and ban smoking on the school grounds in addition to within the buildings. In other words, our concern is that we don't want to simply bump kids off the school grounds on to the streets. When you combine that with the fact that kids may still be able to get cigarettes through some other means, through the black market, for instance, the only idea we've been kicking around is the idea of making it illegal to possess cigarettes, in the same way it is now illegal for a young person to possess alcohol. I'll give you an example.

If you've got two 14-year-old boys sitting on the curb, one smoking and one drinking a beer, the police officer is only going to talk to the kid with the beer. But the studies show us that cigarette smoking, the illnesses connected with tobacco, is the number one preventable source of illness in this country.

It seems to me we are failing to capitalize on an opportunity here to instill a sense of responsibility in our kids so that they know we mean business. I'm just wondering what you think of that idea.

0910

**Mr McKinnon:** I support any kind of law enforcement we could add to the bill, any weight we could add. We would support that. But that's extremely difficult. I understand where you're coming from. I can see that trying to police that would be extremely difficult. I look at our own situation now. The Lakehead Board of Education has a policy which forbids any smoking on any of its properties, and that includes school yards right out to the edge. The problem, of course, is that the kids leave there and go out to the sidewalk of the neighbours, and then the neighbours get all excited—cigarette butts all over the place—so they constantly start to get on the edge of the property, closer and closer. It's a constant battle.

To take your fine point, if it were illegal for anyone under 19 years of age to have a cigarette, that would probably make our job easier, because then we could say, "What you're doing is illegal, and here is the consequence." Right now it's, "Get off the property." We don't have a lot of teeth in that right now. I support what



you're saying. I think that's the next step.

**Mr Jim Wiseman (Durham West):** I'd like to pursue a number of things. First, I'd like to backtrack a bit. What would you suggest should be the legal consequences for anybody under the age of 19 having a cigarette in their possession? When we start talking about consequences, what are we going to do? Are we going to fine them? How big a fine? That kind of thing.

**Mr McKinnon:** I haven't given that a lot of thought, but my immediate reaction would be they could be sentenced to education, if that's not a contradiction. Perhaps they would be obliged to take some extra health courses—I'm not saying this should be put back on to the schools, but a lot of stuff is put back on to the schools, so maybe that's an alternative. Teach them about the consequences and dangers of smoking. Get health care professionals involved in the schools and have noonhour classes or 3:30 classes, because I'm sure we would have lots of clientele.

**Mr Wiseman:** A high school in Sudbury called Lively made a presentation to this committee. They seem to have a rather interesting program there. They brought to the committee three young people, two of them smokers who wanted to quit. I asked them if they had thought about taking those students into the elementary school as peer role models and trying to convince the younger students that it's not really a great idea to begin. We've heard that peer pressure and price are two of the main reasons young people will smoke. The lower the price, the more likely it is they're going to. Of course, we're facing a really interesting problem now because of the federal Liberal government and the former director of Imasco.

My point is, have you thought about any of these kinds of programs in your school? Do you know about what's happening at Lively?

**Mr McKinnon:** I don't know about in Sudbury, but I'm sure there are lots of available strategies. Certainly within our own schools we have talked about, how do we get these kids to simply not start? We have looked at some of our health curriculum dealing specifically with that. We have endless parades of health professionals constantly coming to the schools saying, "Here's the danger, here's the consequence of one cigarette a day," and we do the demonstrations in the classroom. When I started, I taught physical and health education, and we showed the old films. If you go back to the 1960s when those films were pretty graphic—I had kids fainting in the classroom, but they'd go out and have a cigarette to recover, was my sense. I could be a little cynical, but I'm not certain that kind of stuff is effective. I'm sorry, I don't have a particular answer.

**Mr Wiseman:** My last question has to do with enforcement. It is my particular pet peeve that I would like to see incorporated somehow within this bill the civil right of parents and health groups to sue in civil litigation people who sell cigarettes to minors. As a parent who has three young people below the age of 10, I'd like to have the opportunity to sue anybody who entrapped my kids into smoking by giving them free cigarettes or by making it so cheap that it is easily accessible, because we heard

from the addiction centre in Sudbury that as few as four cigarettes will get somebody addicted.

**Mr McKinnon:** I would support that 100%, because any more teeth we can put into a new law would be beneficial. I would think that a few successful suits of that kind would make people sit up and take notice. That's a terrific idea.

**The Chair:** Mr McKinnon, thank you for coming before the committee this morning.

THUNDER BAY HEART AND STROKE FOUNDATION

**The Chair:** I call our second witness, from the Thunder Bay Heart and Stroke Foundation, Mr Jim Morris, president. Thank you for coming this morning. Please go ahead with your submission.

**Dr Jim Morris:** Just one little clarification. You could perhaps add "doctor" in front of "Jim Morris." It's Dr Jim Morris, and the reason I do that is because there is another Jim Morris who is quite well known in Thunder Bay. I often get his phone calls. He's a deputy grand chief of the Nishnawbe-Aski nation and until very recently he lived about two blocks from me, so it was quite confusing. I keep telling people: "Phone me. I'm the good-looking one." In fact, he's on television more than I am.

First of all, I'd like to thank the committee for allowing me to make the presentation, and perhaps I should give a bit of background. Like Brian, who just made his presentation, for 26 years of my life I was a secondary school physical and health education teacher, so I know exactly what Brian was going through when he was talking about trying to prevent smoking in the schools.

For 26 years, and sometimes in a number of grade levels, I would teach about the evils and the hazards of smoking, and I used to take the approach that Third World country educators take, referred to as "each one, teach one." I would start off my lessons by saying: "I'm one individual. I have lots of fallacies and problems and so on, but if during the next few lessons I can affect one of you in the classroom"—and there'd be a classroom of 30 grade 9s, or if it was in the lifestyle classes, grade 11s or grade 12s, or even the grade 13 OAC course that I used to teach—"to make you either not start smoking or to stop smoking, I've done my job. There are 30 of you here. If I affect one of you in that way, and if you in turn can go out and help someone to not start or to stop smoking, you've done your job." You would hope you'd have a better record than that, but that's the way I'd start it off.

A lot of strategies have been tried. You mentioned the Sudbury idea of peer teaching. Back in the early 1980s I was involved with a program here in Thunder Bay that was funded by the Ministry of Health in Kitchener, London and Thunder Bay, and the approach here in Thunder Bay, working with a lot of teenagers, was a peer teaching program which was very successful. We had grade 10 and 11 students going into the grade 5s and 6s, mainly grade 5s, doing peer teaching in the area of smoking. It was highly successful. It was mostly run by volunteers, including myself as head of the committee, but it was the youngsters who were doing it and it was

very successful. The teachers in the elementary schools loved the program.

0920

I'm also a member of the Tobacco-Free Thunder Bay Coalition. As I indicated, since 1980 I've been on the Heart and Stroke Foundation, and this year I'm the president.

Perhaps I should say that heart and stroke foundations have been involved in prevention of smoking for many, many years, since 1952. I would have to say I pretty well follow the party line with Heart and Stroke in the three main areas the bill addresses, and that includes vending machines, as I understand a number of studies have shown many children get their cigarettes from vending machines which are unsupervised.

It's bizarre to think there are health professionals who can defend or even rationalize the sale of a product that is demonstrably harmful to our health and in fact kills people, and at the same time sell things that are supposed to help people, and I'm referring to pharmacies. The College of Pharmacy has asked the government to ban sales of cigarettes in their establishments. Corporate Canada wants to have the freedom to sell cigarettes wherever they want. In years to come I think we will look back at this bizarre situation and bang our heads and say, "What were our legislators thinking of to allow this to happen?" It would be the same as the nursing profession saying: "We want to sell cigarettes at the nursing stations in our hospitals. That's free enterprise; we're retailers." Bizarre.

Increasing the age may have some effect, although as you get older, people tend to get younger and the world moves faster. It's the old policeman syndrome, where you look around and policemen seem to be getting younger as you get older. I don't know whether you have to have people at the retail counters who are the same age as the people they're selling to or realize, "This person is only 17 or 18" because they're in the same age bracket, but certainly that may have some effect.

Going back to the idea of making it illegal for teenagers to have cigarettes, it's the same idea, I suppose, that we could legislate that anybody who smokes sign a waiver that, if they get ill and it can be demonstrated that they became ill because of their cigarettes, we would not pay their health costs.

I read an article many years ago, and I used to quote it in my classes. It was in the Canadian Medical Association Journal and it was called "Don't Bleed on my Carpet." It was written by a physician in Kingston and he pretty well said, "If I'm dealing with a patient who's a smoker and he or she continues to smoke, and then they become ill and they want to be cured, if they don't stop smoking, then I say, 'Don't come and bleed on my carpet.'" He was taking a stand, and this was in the 1960s. He didn't want to deal with smokers if they could not help themselves.

Going back to the bill at hand, I think we should have some form of licensing, and I know Heart and Stroke is pressing for licensing of some nature. The public health inspectors are around the community. There are many of

them in the province. They could simply take that on as something in their job mandate. We may need a few more health inspectors, but it is something they would probably be glad to enforce.

The packaging of cigarettes: Studies have shown that the packaging of cigarettes does have a bearing on what brand people buy. I guess youngsters are like all of us: They're attracted to marketing. Generic packaging, a putrid yellow colour with skull and crossbones and simple letters for the brand name: Wouldn't it be nice if we could have something like this on our packaging?

Modern technology can do wonderful things. I have a little card here that, when you open it up—can you hear it?—it plays the American national anthem. Wouldn't it be nice if we could have a package of cigarettes that, every time it opened, said, "This will kill you, this will kill you, this will kill you." You've got to shut it up, and they'd probably tear them out, but it would make work. This is probably made in Taiwan, but it's making work, and it would be in cigarette packages.

Environmental tobacco smoke: Robin's Donuts—and this is a plug for Robin's Donuts, by the way, folks. There are 17 of them in Thunder Bay and there are 129 across Canada and now in the States. A number of their outlets are smoke-free. I will not drive a mile for a Camel, but I'll drive across Thunder Bay just to go to a Robin's Donuts that's smoke-free, and I know many people who will do that, including some smokers, by the way. To go to a smoke-free environment to enjoy a cup of coffee—and coffee is harmful—in some respects is a treat.

Environmental tobacco smoke is a problem. How we deal with it—whether it's legislated or just the fact that people know they're going to get customers coming to a smoke-free environment. Workplace smoke is certainly something that should be dealt with more severely. I'm not quite sure of the legislation, but 25% of the work area is supposed to be smoke-free, but if you're working next to somebody or in the far corner, the smoke still drifts, so that still is a problem.

One more thing just to wind up, and then I'll answer any questions. Enhancing and increasing support for smoking cessation programs: One thing some employers have tried is that if their employees stop smoking, they'll give them payroll bonuses or some inducements to stop smoking. Wouldn't it be wonderful if the government could encourage employers to have their employees stop smoking, and then somehow or other reward them so that they in turn would reward their employees? Incentives. We, as adults, are role models for our children, and anything we can do in this regard would help.

I know I've gone on, but I'm not quite through my 15 minutes. I'm open to any questions.

**Mr Gary Carr (Oakville South):** Some of your suggestions have been very creative. But if we proceed with this particular bill, do you have any idea of how much impact there will be? What are we going to see in terms of a reduction? It might be difficult to quantify it in terms of a percentage, but if this bill goes through, how much of an impact is it going to have?



**Dr Morris:** If it would prevent one youngster from starting to smoke, or at least make them think until they're 18 or 19 to purchase cigarettes—when I first became involved in Heart and Stroke and as a physical educator, I never thought in my wildest dreams that I would see the day in which there were so many smoke-free areas. When we look back on this part of the century, maybe by the year 2000—and one of the goals of Heart and Stroke is, by the year 2000, to try to get children to stop smoking. But 10 or 12 or 15 years ago, I never thought the high schools in Thunder Bay would be smoke-free, I never thought the hospitals would be smoke-free. It has come so far, so fast, that anything we can do is certainly going to improve the situation.

**Mr Carr:** So you see this as just part of the steps.

**Dr Morris:** As part of the steps. Legislation is probably only one part of it. Perhaps in my lifetime, it'll become socially unacceptable, through peer pressure. Most smokers you talk to now, and there are probably some smokers on the committee—I have friends who won't smoke in my presence because they think I'm with Heart and Stroke. That's weird; they're my good friends.

I recall one incident. I knew a friend smoked but he never, ever had smoked in my presence. I'd known him for 15 years. I pulled up to a stop light and he was in a car beside me. He had a cigarette and it was cute to see the way he immediately dropped the cigarette, as if I was going to—and he's my age, too.

0930

**Mr Carr:** You're right. We have made some very dramatic inroads with a lot of these things. The problem is, though, that they tell us we're still not winning the battle. A lot of kids are starting. Why? We seem to be winning with some of the older folks like myself. Why is it that we're still losing the battle with some of the young kids?

**Dr Morris:** Marketing. The cigarette companies simply will find ways to induce youngsters to continue smoking.

This is a tangential thing. I wish Kurt Browning, when he did his routine—that's an imitative sort of thing. It's from the old Humphrey Bogart movie and so on, and you only have to look at old movies to see how far we've come.

**Interjection:** He threw it away.

**Dr Morris:** He threw it away, but he still was smoking.

I don't know, I just think that you as a committee will probably look back on the committee hearings, and the bill, whatever form it takes, as just one more step. Eventually it may become socially unacceptable, that kids won't start smoking because nobody will be smoking, period.

**The Chair:** Just for the record, I believe this is actually a smoke-free committee. I don't think anybody on the committee smokes. Some may have, but I think we are all fairly pure and pristine.

**Dr Morris:** Isn't it wonderful to be so perfect.

**Mrs Karen Haslam (Perth):** Those of us who have

been on the committee for a long time have heard very similar presentations, and you're probably in the majority of the presentations. We're actually starting to feel sorry for the doctors who must face these people and say: "You're dying. You have lung cancer." For anyone diagnosed with lung cancer, statistics show that the rate of success in beating that kind of cancer is extremely low. As a woman I'm concerned, because we've seen the amount of lung cancer in women triple. That's scary for those of us on the panel who hear these types of things.

You talked of looking at a smoke-free environment or a smoke-free society by the year 2000. I'm quite concerned now, with the policy decisions made at the federal level around the taxes on tobacco, whether you still feel that can be attainable.

**Dr Morris:** It's certainly a major backward step, because all studies show, as someone indicated earlier, that the price of cigarettes is a determining factor in people purchasing them. Whether closet smokers will now come out and smoke more because they're cheaper, I don't know.

**Mrs Haslam:** That's one of my concerns. The other one is around your suggestion about licensing. In the legislation there is a model proposed. If there are at least two convictions of you selling tobacco to minors in a five-year period, it's automatic: You lose the right to sell tobacco. There is a sign put on your establishment saying, "I don't sell tobacco because I am prohibited." There are letters sent to the manufacturers to say, "You cannot sell tobacco to this store." You're not even allowed to store your products and wait it out. There can be no tobacco products in your location.

I was wondering why you would look at licensing over that proposed model. The result or the idea is the same; the model is what's different.

**Dr Morris:** There's no licensing involved in the present legislation, I take it.

**Mrs Haslam:** If you've looked at the legislation—

**Dr Morris:** About two weeks ago.

**Mrs Haslam:** It's a ticketing issue. In a sting operation, if you're proven to have sold to a minor, you are issued a ticket. You can either fight it or not. If you are convicted twice within a five-year period, you lose the privilege of having tobacco on your property, selling tobacco. There's a sign put up that says you can't sell tobacco. The manufacturers are informed you are not allowed to have tobacco; they can't sell you tobacco. It's that kind of model within the legislation.

People are coming and saying: "We'd rather see licensing, where you license every retailer and every gas bar and everybody in the province to sell tobacco. Therefore, when you're convicted, you lose the licence." I was wondering why you're recommending licensing over the model that's already in place in the legislation.

**Dr Morris:** If the legislation, as proposed, is that easily enforceable, then perhaps licensing wouldn't be necessary. Taking away their privilege for recurring sales to minors would be my justification for anything.

**Mrs Haslam:** Do you see enforcement as the key issue in this legislation?

**Dr Morris:** No, I primarily see it as another step in the whole process. Now the government is saying, "We're going to do things to further encourage not to smoke, especially young people."

Just one more anecdote: My first three years of secondary school teaching were in the beautiful island of Jamaica. I taught at a grammar school of about 600 students. After a while, one thing became evident: Not one student in this school smoked. I couldn't get around this until at a staff meeting the headmaster said—this was his expression—"No student is allowed to smoke as long as they are a member of Manning's community." This was in a staff room where there were probably 10 or 12 of the 30 of us who smoked. The rule was that as long as you were a student at that school, you were not allowed to smoke—not off the grounds, not on weekends, not at night. If you were caught and somebody reported that you, as a student, were seen smoking—and we're in a Third World poor country. That was the rule of the school. I haven't been there for a number of years, but no child in that school smoked, and these were 12-year-olds to 18- and 19-year-olds.

**Mrs Haslam:** Was that a public system?

**Dr Morris:** Basically, yes. There were a few funded, but most of the kids paid their own way.

**Mrs Yvonne O'Neill (Ottawa-Rideau):** In the northern communities we've been in, cessation programs have come up more often. You've just suggested that the employers in Thunder Bay are into this kind of mode. I wondered if you could say a little more. Do they offer cessation programs in the workplace without any loss of pay? Are there cessation programs that are part of the credit program in the high schools?

**Dr Morris:** I can speak to the first. Five or six years ago, when many of the public buildings were becoming smoke-free, at the secondaries—all the schools, in fact—the Lakehead board offered two or three sessions for staff. I was involved in several of those. The employer put these on for employees, and I know a number of organizations have had them to help to encourage their employees to stop smoking. In the secondary schools the smoking education is done in the health classes, and I don't believe there are cessation programs as such. It's basically the health education aspect of the phys-ed programs.

**Mrs O'Neill:** It's something that seems very worthwhile, if it can be done. The workplace seems to be an area where we are dragging our feet now after some successes. If employers can be encouraged, there are lots of data to support the fact that they'll get more out of their workers in the end.

**Dr Morris:** The Quetico Centre was one of the leaders in this area, encouraging its employees to stop smoking and giving them enhancements in their pay-cheques and so on.

**The Chair:** Dr Morris, on behalf of the committee, thank you very much for coming here this morning.

**Dr Morris:** It's been a long battle as a professional physical educator, but I think we're winning it.

STEPHEN ROEDDE

**Dr Stephen Roedde:** I'd like to thank you very much for allowing me to come here today. To introduce myself, I'm a full-time emergency physician at McKellar General Hospital here in Thunder Bay. I feel, in some senses, a bit awkward making a presentation to this group among such esteemed colleagues as have just presented.

I'm here because I face the effects of smoking every day and I feel passionately that all of us have a responsibility to do something to try to limit the ill effects of smoking. I'm not an expert in terms of health legislation. I'm not an expert in terms of Bill 119. I'm just somebody who is concerned, who feels that something has to be done, and I wanted to make a presentation essentially to support those people who have worked very hard to prepare what looked to me to be a good document that had a lot of positive components to it, and to make a few observations about some small changes I think might be made.

As I mentioned, I'm an emergency physician. I worked first as a family physician, attempting to get people to quit smoking, facing the frustrations of that. Subsequent to that, I've been working full-time, and every day I see the ill effects of smoking. I see suffocating in front of me people with chronic obstructive lung disease for which I can offer nothing but expensive treatment that palliates them as they slowly go downhill. I see sick kids with asthma who have had their illnesses either caused by or exacerbated by parents who smoke in the home. I see young people, 35-year-olds, initially just men but now increasingly women, having their first heart attacks. Sometimes they die, sometimes they live. We spend a tremendous amount of money and energy trying to treat the effects of smoking. I really believe that the only way we're going to get around this problem is to prevent people from starting, so I think this bill is very good.

I'd like to speak a little bit about section 4, which deals with limiting the sites in which cigarettes can be sold, specifically in terms of the role of pharmacies in the sale of tobacco products. I think this limitation is a really progressive move. I am really dismayed that we have a situation where health professionals are able to sell products that clearly do harm, that clearly kill people, juxtaposed with other products that seem to be helpful and promote health. As others have said, the professional body to which pharmacists belong has spoken out clearly, stating that it does not think this is something pharmacists should be involved with. I certainly support that view.

I assume there will be submissions here and elsewhere from people who have a self-interest in continuing with the sale of tobacco products, and I would be concerned that members of this committee may be swayed by those arguments. This is something that has nothing to do with statistics and numbers and studies. These are people who start smoking, who get sick, who die, who suffer. We see it every day. For those of us who see it, something like banning the association between products that encourage health and those that cause ill health is something that just should occur.

Other types of control of sale should be considered. We have controlled the sale of alcohol products through



specific outlets, I suspect in part because it's easier to control the sales. I hear questions coming from the members of this committee about how one is going to enforce the components of this act and how people who break the law can be dealt with. I would argue that you could make a case for selling tobacco products in branches of the LCBO. We know then that they're not going to be sold to minors. We know then that you're not going to have all the problems with enforcement. That would be simple, possibly too simplistic, but that's something that should be considered.

In addition, in section 5, where it relates to packaging, in my experience as a family physician, there certainly does seem to be some status associated with having a particular brand in one's pocket. I can remember being a part of that when I was an adolescent. Having tobacco products sold in plain, unmarked packages would be a productive step. In doing so, the health warnings would be more prominent. There would be a break in the link between the manufacturers circumventing their advertising through sports and music events, and their brand names. That's something that could be included in this act. I think it would strengthen it significantly.

The last comment I want to make is one about section 9, which I gather deals with the control of smoking in specific environments. Although there are some specific areas in which smoking seems to be banned, it's not clear to me whether that means I and my family will be able to go into a restaurant in Thunder Bay and know we can sit down without being poisoned. The health effects of passive smoke are accumulating and I gather increasingly clear, and it's not clear to me whether I'm going to be protected in that environment. I don't know whether the common areas of shopping malls are going to be areas to which I can bring my kids safely, knowing they're going to be protected from the effects of passive smoke.

I wonder why it's not possible to just prohibit smoking in any place except those in which it is specifically permitted. Let's place the onus on the people who want to encourage or allow smoking to prove that it's going to be safe, rather than the other way around.

My experience as a family physician has really driven me to believe that the things that have affected people in their attempts to quit smoking are the societal changes in attitude. They're no longer feeling it's okay to stop in at somebody's house and light up a smoke, but ask the question, "Is it okay if I smoke here?" and, if it's a non-smoking house, out on to the deck they go. Those are the sorts of changes that make a difference for people, and I think making it less socially acceptable is really going to have a beneficial effect.

To conclude, it's a good bill, from what I can see. I really praise all the people who have worked really hard to bring it to fruition, and I encourage those people who believe in preventive health care in this province to continue to work to prevent this bill from being weakened, and possibly to strengthen it.

**Ms Jenny Carter (Peterborough):** Thank you for your constructive criticism of the bill. I think we're all agreed that the most important thing is to prevent people from starting to smoke, but I was wondering if you as a

physician could tell us something about the difficulties of getting people to stop once they have started. Obviously, we're all aware of different strategies that people pursue to try to quit. Some of us who are not smokers wonder why these people don't get off this habit when they know it's so bad for them. Perhaps we don't understand just how hard it is. So I wonder if you can tell us what kind of prospects people who are maybe your patients have if they are smokers and want to get off it, what strategies they use and how many succeed.

**Dr Roedde:** I'm not an expert on the topic, certainly now that I do not practise primary care and I'm no longer involved in that area of practice, but in the time I did family practice, when people would come in for an annual health, I would ask them about it. I would talk to them about it. I would encourage them. I would ask them to go through the strategies: "Have you ever tried to quit? What things have you tried? What worked for you?" I'd talk about things that may motivate them to stop smoking.

Although there were a few successes, it took a tremendous amount of my time and energy, and patients' time and energy, with very few successes. It seemed to be incredibly difficult. When I was doing it, I believe I was following at the time the best strategies available. Although there are some successes in everybody's day, it just seems to me that the energy spent there would be far better spent at the front end. Obviously, things have to happen as part of the big picture, but it just seems incredibly frustrating to try to do it.

**Ms Carter:** Something like the nicotine patch, for example, is not really a breakthrough?

**Dr Roedde:** Personally, I doubt very much it's a breakthrough. As far as I'm aware, it hasn't been evaluated in comparison to other things that were around before, nicotine gum and so on and so forth. We're often driven by the latest and greatest, most convenient thing, rather than things that are clearly better than what we had before. There are strategies that are effective in getting a small percentage of people to quit. My experience even in emerg, with people who come in with the little patch and the nicotine on their fingers, suggests to me that it's not dramatically effective, although I'm not an expert on the literature.

**Ms Carter:** So the focus has to be on how to prevent people from starting, and you have given us some ideas about how we could strengthen the bill in that respect. What do you think are the main factors that cause youngsters to start smoking?

**Dr Roedde:** I'm not sure I can speak with any more wisdom than any parent. So, I reflect back to my own adolescence and to the kids I saw in practice and in emerg. Sometimes it's being different. Sometimes it's being part of a group. Sometimes it's saying to the rest of the guys: "I'm going to be different. I'm going to do it because I'm different and because you don't want me to do it."

Increasingly I'm seeing groups of young people today speaking out and taking stands about all sorts of things, about drugs, about smoking, about alcohol, about drinking and driving. Even within the youth of today, I see a

lot of encouraging signs that people are not going with the big tide of peer pressure, and they're fighting against it.

I'm not an expert on it. All I can say is that it seems complex, and anything we do to make it more difficult to start, to make it more expensive to continue, to limit access, all those things are going to be effective. It's not going to make it go away, but it will be part of the big picture of making it not okay, in that group as well as in the groups of adults.

**Ms Carter:** If it could be uncool instead of cool, we'd be on our way.

**The Chair:** Dr Roedde, thank you for coming before the committee this morning. We appreciate it.

0950

**Mrs O'Neill:** May I ask the parliamentary assistant a question? Mr O'Connor, would you be able to tell us whether there is some thinking about expanding the areas for non-smoking? The two that have been brought to my attention most frequently since the hearings began, the ones that came to us in Sudbury, and I've had written representation, are the common areas in seniors' housing, particularly public housing, and then the arenas. Can you tell us if there's any intent to expand that section of the bill?

**Mr Larry O'Connor (Durham-York):** The housing area could be problematic. We'd have to get some clearer definition and some help from Housing to deal with that. It's probably easier to deal with the arenas through this legislation.

#### LAKEHEAD WOMEN TEACHERS' ASSOCIATION

**Ms Julie McKay:** Good morning. My name is Julie McKay. I am a teacher and the president of the Lakehead Women Teachers' Association, which is one of 80 associations that form our larger provincial group, the Federation of Women Teachers' Associations of Ontario. We represent 42,000 elementary women teachers. In Thunder Bay locally, I represent 500 women teachers.

I thank you for the opportunity to present our concerns regarding the Tobacco Control Act, Bill 119.

The stand our organization takes is very clear in our provincial constitution, and I quote, "That the teaching of the prevention of smoking should be a component of the health curriculum in the primary division."

Smoking is dangerous to our health. This has been stated by the medical profession and also supported by the statistics from the Canadian Cancer Society. I'm here to ask that the community, parents, teachers, business and industry unite in a partnership with a common goal, that goal being our future. As educators, we can only do so much to combat the situation with smoking. Success depends on all aspects of society working together. This partnership must focus on our future as a community, a province and a country.

Our future is our youth, and our future will be as strong as is our youth. Smoking and its devastating effects cost many lives, many thousands of dollars, and promote neither health nor strength.

We compliment the Honourable Minister of Health,

Ruth Grier, for bringing this bill forward, and we recognize the support and hard work put forward by Larry O'Connor and many other dedicated politicians.

We are in support of Bill 119, as it addresses our concerns. Bill 119 will prevent the exploitation of our children and youth: exploitation of our youth at their health expense, exploitation of our youth at their financial expense. It is not justifiable that children and young people have the pressures of advertising companies, specifically with the intent to get them to try smoking and then to get them hooked on smoking. Tobacco companies spend hundreds of thousands of dollars on marketing strategies and ads resulting in promotions that are directly aimed at young people.

Vending machines are made for easy access, especially by the underaged. Vending machines are unsupervised, they do not have a conscience, nor do they care or ask for the age of majority or proof of age. New York City does not have any cigarette vending machines, as quoted in the OCAT report, December 1993.

Selling cigarettes in health facilities of any type, pharmacies, health clubs, clinics, is a contradiction to the very existence of that facility, and the sale of this product should be prohibited there. It gives our children a mixed message.

Raising the age can help delay the process a bit, as young people usually start before the age of 20. If we prohibit and restrict smoking in public areas, we will be improving the quality of life for everyone, you and I.

Our interest is our future and our quality of life. We feel that Bill 119 is very important in addressing all of our concerns. As educators, as citizens, and as partners in our community, we support this bill. We will be paying very close attention to the procedures in the Legislature as Bill 119 is considered. Working together, we can make a difference. Our children deserve that consideration and the right to a healthy future. Our responsibility as citizens and adults in this country is to provide it.

**Mrs Haslam:** A number of us around the table are former teachers, and we share your concern for the young people.

It's nice to say, "Thank you, Ruth," and "Thank you, Larry O'Connor," but I must say that everyone around the table has worked very hard. Mr McGuinty brought in a private member's bill, and Mr Arnott from the Progressive Conservative Party, who's a former member of the committee, has done extensive work in his own community around it. On behalf of all the parties, I'd like to say there are many people here who are very keen on seeing this legislation be successful. It is for the young people.

We've been receiving statistics that say 3,000 young people a month start smoking in Ontario. I've checked those with everybody who has said that. I was talking this morning with someone who said that with the lowering of the taxes recently at the federal level, the accessibility in price being easier for young people, they are afraid somewhere between 4,000 and 6,000 new young people a month in Ontario will start smoking. This is a concern.

You mentioned strong words here and that's why I've



zeroed in on them, because I'm wondering if this is the message we should be giving to our young people. In elementary schools, the message is easier in the health care idea, that smoking is bad for you. We get letters from young young people saying: "Thank you for coming and talking to us from the cancer society. I'll never smoke." But when we get to the secondary level, it seems to be much more difficult to get the message across to secondary school students.

I'm wondering if our message should be more the idea of: "You are being exploited by a marketing firm. You are being exploited to take the place of those people who have died using this product. You are being exploited to become hooked on a drug." Is that a stronger message we should be giving to our young people?

**Ms McKay:** I was bringing forward, as is our association, the idea that young people are taken advantage of. In the elementary, we can start at an earlier age level to put through the concept that it is not good for you. We still do have difficulty when we reach the intermediate grades, because there is peer pressure. Though we want to remove that, it is there. If the price of the cigarettes is at a level that they are accessible, they will try it. We all try something we can access. That certainly will move it, through that.

1000

The exploitation is the advertising, the appeal of the cigarette, the stereotype or the image that is involved, just as in the commercials that used to be on the media that referred to alcohol, it was always something special to be able to take part in that. If we can work against that kind of advertising so that our children and our young people have the opportunity to be away from that pressure until perhaps a later age—we have been given the statistics that they start smoking before 20, so if we had a legal age, that would probably curb a lot of the new beginners.

**The Chair:** Thank you very much for coming before the committee this morning.

STUART HOLTBY

H.S. DHALIWAL

**Dr Stuart Holtby:** Good morning, ladies and gentlemen. My name is Stuart Holtby. I am a medical doctor, a lung specialist practising in Thunder Bay. I am very grateful for the opportunity to speak to you. First off, I would like to offer you all my congratulations on working together to bring this legislation forward. I hope there will be continued cooperation in not only bringing this legislation through the Legislature but also speedily writing the regulations and implementing them.

The many organizations that support this act have provided you with solidly based, articulate arguments for all its provisions and also for extension of the act in a number of areas, including plain packaging, licensing and environmental tobacco smoke. I will not restate those arguments. Rather, I bring to you a message of support that you might not otherwise hear.

Like you, I spend much of my day listening to people, listening to them present their stories and their problems. Unlike you perhaps, most of the people I see have not seen any benefit or advantage from the tobacco industry.

Indeed, most of the people I see have been hurt by the tobacco industry, savagely hurt by the tobacco industry.

Most of my patients are far beyond any remedy this legislation might offer, yet they are among the most fervent supporters of this. They speak to me with nearly one voice in support of this, and now I speak to you for them. I speak to you for the families they have left behind. I speak with the voices of the people who are your constituents, who are this province. I speak to you with the voices of those whose breath to be heard has been stolen for profit. I am speaking to you standing at their bedside. I am speaking to you standing on the graves of people who put you in office to make this land a better place.

Here is one of their messages entrusted to me to bring to you: "Keep our children from tobacco. Tobacco will enslave them, impoverish them, torture them; tobacco will kill them. Do not let that happen. Do not fill your pockets with their suffering. You, all of you, have the power to stop the tobacco industry. The people are behind you and with you to help you use that power. Do not falter. Do not forget."

The man who gave those words to me died in December of emphysema. I can think of no more compelling message for you to recall.

**Dr H.S. Dhaliwal:** My name is Dhaliwal. I'm a cancer physician and head of medical oncology at the Thunder Bay Regional Cancer Centre. I represent the OMA and the Thunder Bay Regional Cancer Centre, but above all I really speak to you in good faith on behalf of hundreds of silent patients who have succumbed to the ravages of disease that Dr Holtby has described. I echo his comments.

In the five minutes I have I'd like to make three points.

First, Bill 119, the Tobacco Control Act, in my opinion is easily the most important piece of health legislation in the preventive field ever introduced in Ontario. I choose these words carefully. I would like to congratulate the government and the members of the political parties in supporting this farsighted and courageous piece of legislation.

Second, I want to comment on some aspects of the legislation from the perspective of a cancer physician.

Third, I want to suggest changes to strengthen the bill, not to dilute it the way the vested interests are urging you to do, so that we send a clear message to what someone aptly termed "merchants of death" that their wily schemes will not deflect the government or the people of Ontario from the just path of limiting and eradicating tobacco.

Why do I regard this legislation as important? The answer is simple. The act, if applied effectively, will prevent more disease than I and my other cancer physician colleagues in Ontario are ever going to be able to cure over the rest of our lives. Please take note. Historically, the concept that one ounce of prevention is worth a pound of cure is well proven and beyond doubt, and you all know it. I do not need to reiterate that.

It was interesting for me to listen recently to the famous octogenarian professor Richard Doll, who

lamented that his first paper linking cigarette smoke to lung cancer was published 52 years ago and that sadly, he says, the consumption of tobacco continues to increase. I could add, when will we ever learn? What does it take for us to learn? I spend much of my time fighting to alleviate the misery and suffering directly due to tobacco addiction. Many patients ask me, "Have we found the cause of cancer?" In frustration, sometimes I say facetiously: "Yes, we do know the cause of the commonest cancer. It's cigarettes." But they're always surprised by the answer a little. Most times I keep quiet; it's too late for them. Some will say, "Don't let this happen to someone else."

It's with this background that I really plead with you. I don't have the power to cure, but you have the power to prevent this slaughter of innocents. It really is a slow genocide, if you think about it. If the same number of Ontarians who died, 13,000 a year, and millions of others all over the world, died more vocally, there would be an uproar that we could not ignore. But silently, cancer kills, and we seem to be able to ignore, and the slowness blinds us into inaction.

1010

Let me give you an example. If the panel could wave a magic wand and stop all smoking by dawn tomorrow, the so-called latent period of cancer means I will still be trying to treat cancer for the rest of my life, and so will Dr Holtby be treating the consequences of respiratory disease for the next 20 years. It is so important at this stage that we do not allow our path to be deflected and act quickly. Every day children are becoming addicted, and they cannot stop once they are addicted.

I urge the government not to start dismantling and emasculating this brave act at the behest of vested interests, of powerful organizations that are morally corrupt and ethically bankrupt but have tons of money to manipulate us all. They tell us that we should not have the legislation banning sale of cigarettes in pharmacies. If I told you that as a cancer physician, in order to make ends meet I also had to sell cigarettes, I wonder what your response would be to my testimony. It deserves the contempt that you should all pour on it.

The three measures I would advocate strongly:

First, a retailer licensing system. That's been proven to be effective in some other communities, and those data are available. It will allow close monitoring of vendors, encourage responsible behaviour and increase compliance with the law.

I'll give you an example. Coming from England, in the first few months, not being fully aware, I drove at the usual speed in England until my driving licence hung by a thread. I no longer speed.

Plain packaging is the second point I would urge the committee to recommend. Take the glamour out of cigarettes, please. The tobacco industry's own research in advertising proves that it increases sales, that there are multiple ways to glamorize the product, bypass the restrictions, target specific groups like the women with these slim cigarettes. Women have the highest rate of increase in cancer at this moment. Cigarette-caused lung

cancer, as you know, now exceeds breast cancer.

In summary, as a citizen, father, and physician, I strongly applaud the introduction of this legislation. Someone compared it to the launching of a ship of hope. Those who care about human misery and suffering are aboard. It needs some extra sails to strengthen it. Please don't let the saboteurs hack away at the masts and drill holes below the waterline and sink it in the harbour. For God's sake, don't let them. If you succeed, the mothers, fathers, sons and daughters who will be spared the painful consequences of tobacco addiction will thank you for generations. Please pass this legislation and strengthen it. Thank you.

**Mr McGuinty:** Thank you very much for your very articulate, moving and compelling presentation. I have to ask you this, though. Why aren't we addressing and why haven't you addressed the big problem, which is that we have over the years developed as a society, as a country, a terrible dependency on the tobacco industry. This dependency is not like a tumour we could excise or a piece of fat on the outside of meat; it's marbled throughout.

Just to give you an example, as a result of the recent decrease in the tobacco tax, apparently that affects the consumer price index, which is partly a function of the price of a pack of cigarettes, which in turn affects the CPP payments. Some seniors have started to complain that CPP payments will not go up quickly enough because they're a function of the consumer price index, which is a function of the tobacco tax.

Why don't we attack the problem itself, which is the tobacco industry? I'm not sure how we'd go about doing this, but I'd really like to see a presenter come forward with a long-range plan. How do we phase the tobacco industry out?

**Dr Holtby:** Sir, you have that long-range plan in front of you.

**Mr McGuinty:** I can't see it.

**Dr Holtby:** If you lack the documents from OCAT to support what we need to do to cut away the generation of smokers coming, we will see that you get it in your office tomorrow, sir.

**Mr McGuinty:** No, I'm talking about the farmers, and we've got 100,000 retailers who are earning their living with this.

**Dr Holtby:** Sir, name one pharmacy that has gone out of business because it stopped selling tobacco. Name one place in this province where there has been clear evidence of a business closing or suffering because it has voluntarily chosen to give up tobacco. We are not talking about jobs here; we are talking about death. We are talking about a product that kills when used exactly as intended. The stakes in this game are extremely high.

I'll make just one last point: The revenue that your government administrators generated by tobacco just covers the health cost of it—in the past.

**Dr Dhaliwal:** Barely.

**Dr Holtby:** Barely. And now that the taxes have gone down, it will not cover the cost of health care. The



money from the industry, the money from the taxes, just covers the cost.

Ladies and gentlemen, we have been through very difficult economic times, and I'm sure there has been harsh criticism of what the NDP has done economically in this area. There is a clear need to take the legislative steps now to stop the appeal of tobacco, to regulate the sale of tobacco. That's what we're talking about doing. That is the clear need. If we do those things, then in time the effect of the tobacco industry will wane and the economic necessity will wane.

The people who are addicted now will not stop smoking tomorrow. They're addicted. The guy who wrote those words smoked until he died.

**Dr Dhaliwal:** Society can be weaned. As you well know, there are many societies that exist without smoking at all. I come from one of those societies, and it isn't an absolute necessity. As you know, this is the first legislation we're effectively talking about in Ontario, yet hundreds of thousands of people have given up smoking, some 20% reduction. If you continue that trend by strengthening those measures, then you will wean society off, but it is as addictive as heroin. Would you use the same argument and say that because we depend on some of the revenues from heroin filtering, in illegal ways, into our society, we should continue that?

1020

**Mr McGuinty:** Gentlemen, please don't be too quick to misinterpret me. First of all, you should understand that this legislation will, in all likelihood, receive unanimous support. My concern is with the big picture and the big mixed message, which is that now you've got to be 19, now you've got to be an adult, before you can get hooked. How do we get it away from the over 19-year-olds?

**Dr Dhaliwal:** You start getting hooked from the day you start experimenting with cigarettes, and I have known seven-year-olds experiment. That is why we urge control of access; just pure preaching will not do any good. Control of access is a vital part of that strategy.

**Dr Holtby:** You say, "Keep the big picture." Well, keep the big picture. Nineteen is a small detail. The longer you delay access, the fewer people will begin.

**Mr Wiseman:** One of my other pet peeves is that we calculate the consumer price index on a package of goods that should not be included, such as taxes and taxes on cigarettes and the purchase of cigarettes, something I think we need to look at.

Also, in terms of revenue, it's about \$900 million the province receives. I would think the health care costs associated with paying for cancer and heart disease and other smoking-related illnesses—when you go to a doctor, the first thing they ask you about any illness you're showing symptoms of is, "Do you smoke or drink?" The costs have got to be way, way beyond a billion dollars.

I think parents and health organizations should have the right to sue vendors or people who give cigarettes to young kids, as a means of enforcing.

**Dr Holtby:** If there's a fine system, you're going to

have a problem. The police are not going to be keen on fining the poor corner store owner who gets duped into selling cigarettes to someone, but if all that's riding on it is his licence—and I can tell you that right now, today, I have three Boy Scout troops interested in being the licence patrol.

With licensing, if you sell cigarettes to an underage person, you lose your licence, perhaps for a week. The second time you might lose it for ever. No one gets fined. It's easy to enforce. It's highly effective. Other areas that have done it have found it extremely successful.

**Dr Dhaliwal:** Apart from the costs, we must keep in mind the misery and the suffering. That is unquantifiable. That's what I see. I cannot measure it in pounds, in dollars, in cents.

**Dr Holtby:** We're not here because someone's paying us. We're not here as a lobbyist for some group. It costs me money to be here. My overhead's stacking up as I sit here. I've got work to do. I'm going from here to do work. Why do you think I'm here? I see the effects of this every day. I have people saying: "I can't stop. Why did I ever start?" You people can help people not start. For God's sake, do it.

**The Chair:** Gentlemen, thank you very much for coming here this morning.

RYAN FITZPATRICK

**Mr Ryan Fitzpatrick:** My name is Ryan Fitzpatrick and I'm here today representing myself and my friends. Thank you for giving me this chance to speak in favour of the proposed legislation that will protect me and my friends from becoming addicted to cigarette smoking.

Cigarette smoking is not something our parents, teachers and doctors want us to do. They teach us to respect others, get good educations and live healthy lives. Why then would certain people make young people get hooked on something that will affect our good health and offend the people around us?

We all know that the legal age for smoking is 18. Do I look 18? I don't think so. I am 12 years old, yet I was able to purchase these cigarettes from many stores very, very easily. Now, buckle your seatbelts, hold your stomachs, put on those oxygen masks, because this is going to be a bumpy ride. These stores include: two very small corner stores, Esso gas stations, Suny's gas stations, Mike's Mart, the Great Canadian Superstore, Safeway and Shoppers Drug Mart.

Drugstores are places to buy medicine to make you get better. Why would they want to sell drugs that make you sick? Grocery stores are places to buy nutritious foods to keep you healthy. Why would they want to sell drugs to make you have bad health?

The clerks in these stores didn't feel any guilt whatsoever when they took my money. For instance, I walked into a gas station, Suny's Gas, and I said, "My dad's out in the car and he just asked me to pick up some cigarettes." He was talking on the phone. He didn't look at me or anything. He just threw down the cigarettes and took my money. He didn't ask any questions.

Then there are the vending machines. Nobody saw me, nobody cared. I just put in my quarters and pulled the

knob. I easily got them from family restaurants, including Swiss Chalet, Casey's Restaurant etc, also the cigarette vending machines at recreation centres, such as local ski areas. Vending machines are a real treat for kids like me under 18 who want to start smoking.

The packages are designed to look nice so kids like me want to buy certain packages. For instance, the way I picked my cigarettes is I walked in and looked for the best-looking package—like this. It's very nice looking. It's all nice and gold and looks rich. It makes me almost want to smoke them, maybe.

Bill 119 will help these problems.

(1) Give us kids a chance. Stop making it easy for us to become addicted to cigarette smoking. Don't let stores sell cigarettes to young people.

(2) Make it impossible for me to buy cigarettes at all stores. Put cigarettes in beer and liquor stores. It might even help half the population quit.

(3) Take away vending machines that will take anybody's money, regardless of age.

(4) Quit making designer packages that will make us want to buy certain brands. Plain packaging would be better, it would be definitely better.

Break the habit. It's not too late to break the bad habit of making it easy for young people to buy cigarettes. Help kids develop good habits. This new legislation is a healthy start. Thank you.

**Mrs O'Neill:** Thank you so much, Ryan. It's one of the best presentations we've had, because what you say is so authentic.

Would you say something about illegal cigarettes? Have you had that opportunity? You've had opportunity on the legal market. Has the contraband market approached you or are you aware of its presence in your circles in Thunder Bay?

**Mr Fitzpatrick:** I'm sorry, please rephrase that.

**Mrs O'Neill:** Has anyone approached you and offered you very cheap cigarettes, smuggled cigarettes?

**Mr Fitzpatrick:** No.

**Mrs O'Neill:** So that's not a problem in the area. Well, that's good news for us. Thank you so much for your presentation. We found it very meaningful.

**Mr Carr:** Thank you very much for a good presentation. Obviously, you did quite a bit of work.

I was interested in your thoughts with regard to the price of cigarettes. I take it that you got the money from somebody to do your purchases. We may take one step forward with this piece of legislation, but before the next budget this government will reduce the price of cigarettes, I suspect—but not necessarily—as the federal government has done, and Quebec. So we'll take one step forward and take one step back.

How much of an effect does the cost of cigarettes have on young people? You can do it very easily now, as you proved. This bill will make it tougher. How much, in kids your age, is cost a factor in buying them? Do you know from your friends' experience?

**Mr Fitzpatrick:** Tons of my friends smoke. They don't really mind the price. As long as they're seeing smoke come out of their mouths, they're just happy the way that is. They wouldn't care if they're taking most of their allowance and going down to the store; it's basically nothing.

**Mr Carr:** With the price of cigarettes, the allowances must be up a bit higher than they were in my day.

We've asked experts the reason kids are smoking. Maybe you could just give us your perspective. What do your friends tell you about why they are smoking?

**Mr Fitzpatrick:** They smoke because they think it's cool, just to see a pack like this in their pocket, to wave it around and see smoke come out of their mouths, just to sit around and be cool, I guess.

**Mr Carr:** A lot of the reason, I think, is that they want to look older. You don't need cigarettes. Anybody listening to your presentation would certainly think you're a lot older than 12 years old. You've done an excellent job. I've seen presenters who have done hundreds of these things and they haven't done as good a job as you. If you can take anything back to your friends, it's that it isn't the cigarettes that make you look older, it's the way you present yourself, and you've done an excellent job here today.

**Mrs Haslam:** Actually, when you're my age you don't want to look older. You can take that message back to the young women in your class.

**Mr Wiseman:** She doesn't smoke either.

**Mrs Haslam:** No, I don't smoke; I never have. But I used to be a teacher and I'm very interested in young people, very interested in how we can get the message out, and I ask those kinds of questions in this committee. It's really one of my strongest cares, the young people. Right now I have a 20-year-old and a 21-year-old, so it's like Mr Wiseman, with children coming up to the magic age of 12. He's scared to death, I'll tell you. He's scared to death because his young daughter is coming to the age of 10 and 11, and that's why he wants to sue the pants off anybody who gives his daughter cigarettes. That's why he's so concerned.

In my day you used to go out on the corner and it used to be that it wasn't cool. It was the troublemakers, with the slicked-back hair and the rolled-up sleeves—now I'm aging myself—but it wasn't as if they were the group I wanted to belong to. Has that changed now? Is it the perception of young people that it's the cool ones, the popular ones, who are smoking? I was under the impression that it had changed in the last few years, that you're cool if you don't smoke. Is that perception changing in school?

**Mr Fitzpatrick:** In my school, it is the popular kids who do smoke. They're not the slicked-back, bad people; they're any normal, good kid or kid you wouldn't even notice. There are girls in my class who smoke. You'd think boys would do it, but there are lots of people.

**Mrs Haslam:** That's the other detail that really bothers me, that the percentage of young girls smoking is higher than the percentage of young boys smoking. I have my own opinion, and it's a very feminist opinion,



about the self-esteem of young women and why they smoke and why they hang around with boys who smoke, so don't get me started on that one.

The other question I have is around marketing. We've just had a person present who said that we're exploiting our youth, the marketing is exploiting our young people. When my daughter was going through high school, not elementary school, they looked at marketing. They came home and cut things out of magazines to say, "What kind of marketing tools, what age level were they gearing these to? Why was I so eager to buy this brand of jeans versus this brand?"

Is there any of that kind of class at your level? Would it make a difference if the message was: "You're being exploited, you're being used by a conglomerate that posted a \$125-million profit for one quarter of its year"? Would that message get to you more than "It's cool"?

**Mr Fitzpatrick:** If Michael Jordan, say, or someone like that was advertising cigarettes, I think kids would buy them, but if someone like a 16-year-old person was advertising them, they'd think, "Oh, gross." You see in beer commercials 20-year-old women, all beautiful and everything, and they're all jumping around, all having parties, and you think it's pretty cool. But if you saw someone who wasn't, well—

**Mrs Haslam:** If you're more aware of that fact, as you are, if you're more aware of the effects of marketing certain products, would it change your perception of the need or the desire to smoke?

**Mr Fitzpatrick:** Yes.

**Mrs Haslam:** It would. You have survived peer pressure.

**Mr Wiseman:** So far.

**Mrs Haslam:** So far. That concerns me. I had a son who survived peer pressure, with a mother who didn't smoke and a father who said, "Don't smoke," until he was 19. I could cry that he didn't make it to 20. I congratulate you on surviving peer pressure. How were you able to do that?

**Mr Fitzpatrick:** It's sort of like saying: "Would you like to see me like this when I'm 20?" I'll be coming to Dr Holby and be put in a hospital bed saying I'm all sick and everything. I wouldn't like that to happen to me. I hear all the stories he's told about people dying. It's just not worth it.

**Mrs Haslam:** I congratulate you and perhaps Mr Perley at the back from the association of non-smokers' rights would like to sign you up now for his organization. If this legislation is a step—and it is a step. It's not perfect. I don't think we'll ever see a perfect world. I don't think any government will ever come up with perfect legislation. I think this is a really good step and I think he could use you in another five or six years. Good luck.

**The Chair:** Ryan, on behalf of all the members of the committee, we thank you for all the work you put into your presentation and for coming here this morning.

**Mr Jim Green:** Good morning. I'm Jim Green, district president of the Ontario Public School Teachers' Federation. The federation represents approximately 30,000 educational professionals, and locally I represent approximately 500 educational professionals. I'm the official spokesman for the 500 and have the approval of the 30,000 to be here.

I didn't want to give you a written brief because you will get enough information with the facts and figures from other groups. I wanted you to be aware that teachers are concerned. We have worked long and hard to educate children about healthy lifestyles. Our group has gone so far as to pass specific motions at our annual meeting to direct teachers to attempt to reduce the incidence of smoking among children. We have debated quite heavily how to do this. We have lobbied to have schools made into smoke-free environments, and we're continually working to develop incentives and support programs to encourage smokers to restrict or quit smoking.

From personal experience, I believe the concept of preventing children from smoking before they reach 20 years of age is an excellent move. Most smokers I know started prior to being 20 years old, and I would be among them were it not for health problems in my youth. So I must commend the government for taking this initiative, and the other members here for searching out the information and supporting it.

We in the Lakehead Board of Education have a smoke-free policy. I notice there are still some students standing out on the curb smoking at some of the high schools. Perhaps making the possession of tobacco illegal will help some of the schools to deal with this issue.

Having been a former operator of vending machines, I understand the concern about free access. I'm not going to suggest that they're an evil item, but the control is difficult, and not having seen a satisfactory control, I believe this may be an appropriate move. If the city of New York can do it, I guess the province of Ontario can.

I just wanted to make very clear that as teachers, we're concerned for the students. We need all the support we can get, and we believe this legislation will provide support for the classroom teachers when they are bringing forward to the students healthy lifestyles, which exclude smoking.

The only really unfortunate part I see in this legislation is that it doesn't seem to address the issue of banning smoking in places where you can consume food. I sure would like to see restaurants all smoke-free. I patronize the two local restaurants I know of that are smoke-free. Part of the problem with restaurants is that if a neighbour doesn't ban smoking, others are forced to follow suit and not ban it for fear of losing business. If no one can do it, it will work for all.

I see this legislation as a good first step in dealing with youth, and I hope you will continue on with it and enhance it later to look after healthy lifestyles for the rest of us.

**Mr O'Connor:** To clarify, New York City doesn't have a total ban. It's very restrictive, but not a total ban.

One thing we have had some discussion about around

the committee table was putting the onus on the young people. When Ryan was before us just a moment ago, the thought crossed my mind, should a person his age be the one we're going after? Should we have arrested him, busted the kid as he's leaving because he's been out there purchasing cigarettes to make a point? I don't know whether putting the onus on the young people who are the target of a very seductive advertising campaign—of course, they're not allowed to advertise in this country, but it certainly does take place. What are your thoughts on that element?

**Mr Green:** I see the young people as the key, no question. We see it in the elementary, that students are smoking. Anything we can do to make it more difficult for them to access cigarettes and anything we can do to educate them about why they shouldn't access cigarettes will go hand in hand to help reduce the number of students who smoke. We believe we're doing all we can at the school level. This government initiative will give us some much-needed support, and in the long run it will pay off for all of us.

**Mr Wiseman:** Just a comment on Ryan's presentation. It seemed to me that what he was asking was for us as adults to protect him. While he was presenting a very mature and very well-thought-out presentation about why we should pass this legislation, there seemed to be an undertone that he's also saying that as adults and people who know this, for those who haven't matured to his understanding, we are really here to protect other young people from what is going on with the slick advertising and so on.

We've heard from other groups about peer pressure being an important issue, and we heard earlier from Dr Jim Morris, who used to be a principal, that in the 1960s or in the 1970s they would have peer groups go into the elementary school and discuss with the youngsters about not smoking. Is that still in existence, and if it isn't, do you know why it would have ended or it can't be re-established?

**Mr Green:** I'm not specifically aware of the program. I know in our system teachers are always looking for ways to get the message across, and I'm sure any peer messages they can bring, they do, but I'm not familiar with this one.

I do know the strength of peer pressure, though. In my own family, my son did not smoke as long as he was at home. When he went away, less than 20, he spent his two years in university rooming with people who did smoke, and that was enough influence to make him into a smoker. Anything that can be done, I think is wise.

**The Vice-Chair (Mr Ron Eddy):** Thank you for your presentation. We appreciate your coming before the committee.

DAVID WILLIAMS

**Dr David Williams:** I'd like to thank all the members of the committee for the opportunity to speak with you today. My role here is, well, more than threefold. I am the medical officer of health for the district of Thunder Bay. I'm the acting medical officer of health for the northwestern Ontario health unit. I'm also the vice-chair

of the OMA section of public health physicians. I am also a father of four children, and I can speak about it from a personal perspective as well. So on all those opportunities, I would like to address the issues today.

As has already been mentioned by others, I'd like to congratulate the present government on its stand in bringing forward and placing this bill in the Legislature. I think it is critical at this time that we make a stand and move ahead on this issue. I'm very disappointed in the federal government's move to roll back the taxes and the costs that are there.

If I can use an analogy, since I'm speaking on public health issues, it's akin to having an outbreak of infectious hepatitis in a large camp and a decision's made to curtail hand-washing prior to eating because there have been squabbles in the line over the people cutting the washing and getting into the food line first. It solves one problem, but it creates a major epidemic in the long run.

I won't talk about all the issues of the act, so you don't have to worry about that, and I won't give you a whole collection of data and statistics. You have already received much of that in various formats. But I do want to speak on some issues.

One aspect I won't deal with is the accessibility. Ryan did a great job on presenting that. It is not a problem in northern Ontario. Accessibility is a free game, and there's no issue. The students have access any time, anywhere.

My one role is to speak on northern Ontario. What are the perspectives we face here? What is the epidemic in tobacco we face here, especially among our youth?

In the jurisdiction I cover, which is pretty well a third of the province, and the populations that are involved there, including the aboriginal population, we have some very disturbing statistics to put forward. One is that in our females aged 12 to 19, our average of smoking is 46% compared to the provincial average of 18%. Male and female combined aged 12 to 19 is 37% compared to the provincial average. In the low-income group, 47% of low-income people smoke compared to the provincial average of 33%.

In terms of some of the questions asked before regarding what the impact is of early smoking upon you, when you look at how many people in northwestern Ontario began smoking prior to the age of 18, it was disturbing to note that among the males in northern Ontario, 80% had started prior to the age of 18 compared to the provincial average of 67%. In the women, up till now, and no doubt it's going up all the time, 66% commenced before the age of 18 compared to 59% in the province as a whole.

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It's important to note that with those children brought up in northwestern Ontario, the likelihood of having one or more people in the household who smoke is twice the provincial average. The accessibility to secondhand smoke is there all the time, not only in that sphere, but also, as alluded to by the previous speaker, wherever you go, the number of people smoking in public establishments is tremendously larger than in southern Ontario. I know that, because I came from southern Ontario three



years ago. This is of great concern.

The other thing local data indicate is that among our grade 9 and 10 students—and we'll show some data on that later, what we've done locally—over 40% are already smoking by grade 9 or 10 in a significant form, as compared to 18% in the provincial average.

We have to ask ourselves, why is smoking worse in the north? Is peer pressure worse in the north than down south? Why are teens taking up the habit at an earlier rate and a higher rate than the provincial average?

Easier access has been noted already, and that is a great issue to overcome. Various methods are laid out in the bill that will deal with that, not strong enough perhaps.

There's greater exposure to secondhand smoke and environmental smoke from childhood and from infancy and prior to birth. You only have to watch what's happening around the area, and I'll cover that when I cover environmental tobacco smoke.

We lack initiatives in laying down bylaws throughout our areas, and I'll talk about that in the third point I'm going to raise.

There's very little impact on safety in the workplace, smoke-free environments. The act has made very little impact, and this is especially concerning with a number of summer students who work in these environments.

On that point, we have a very big problem in northern Ontario. It's a big problem across the province and in the country. I think Ontario can lead the way in dealing with a number of these issues, as laid out by the Premier's health council on prevention and promotion, and we should take those strides.

One of the main concerns I have in this area is dealing with environmental tobacco smoke. There are plenty of data out there, and I have a number of articles, even in the last year, indicating the impact this has on children who are passively taking up cigarette smoke, with the levels of the byproducts of nicotine in their urine samples. Also, with infants and the effect on the unborn child, that is there all the time. We have a large number of mothers who smoke in pregnancy, and especially with the younger teens the concern is that by the time you figure out you might be pregnant, you're already into your second trimester and a lot of the impact has already taken place.

The immensity of this problem in northern Ontario is that children like Ryan really have very little choice but to go into establishments and be exposed to this, whether it's a McDonald's—which surprises you; it's a children's restaurant and it's inundated by smoke—or most of the other restaurants around the area. As well, there are areas in schools where teachers are allowed to smoke in lounges. You say, "Well, that's maybe not a problem."

The problem in northern Ontario is that people want to be very efficient in their heat costs. Therefore, external air exchange is minimized. We often go in and have to investigate in our public health role CO<sub>2</sub> contents in schools and public buildings and find to our surprise that someone has been overenthusiastic and cut back the exchange so it's less than 25%. This means any smoke in

the area is circulated freely around to everyone to inhale all day long.

One only has to sympathize in looking at one or two children strapped in car seats in the back of private vehicles while two or three adults sit there and smoke for hours on end with the windows rolled up for hours and the heat system put on recirc, or in a taxicab we have to sit there, or the driver, and breathe this stuff hour after hour. Bingo halls are notorious. I don't know how you can see the cards sometimes. It's so thick you can cut it with a knife.

What does this mean for our children? This means children are exposed to enough smoke to make them already pre-addicted, I feel, and open to greater perception later on. Myself, I have an irritated airway and I have to use this from time to time, especially in a smoke-filled environment. When we're going along the highway—and this is a problem with tourism—sometimes you'll have to get your food and quickly go outside and eat in the car, because when you have over 60% to 70% of patrons in there smoking heavily, you can hardly breathe at times.

The act, while bringing about some rules limiting and asking for bylaws, I feel is lacking the teeth to move forward on that issue, both with the municipalities to deal with and also with local establishments. As the former speaker said, if I'm the only one on the street, it's very difficult, but if everybody else goes by the same rules, it's fair and it's fair game for everyone.

We have to deal with this very seriously in the province, that a lot of our children are being pre-addicted to tobacco and the influences of that and therefore are resulting in a whole new generation of future smokers coming up.

That leads into the third point, which is around bylaws. We did a survey of the bylaws around our whole area here and of all the municipalities. We have a lot of small ones, and they have to deal with a lot of local pressure. On most councils, a large percentage are smokers. Nevertheless, they have a strong desire to see some protection of their youth, and I know they are sincere in that.

The thing is, do you have the wherewithal to move the bylaws forward? Is there a model bylaw the province would put forward in the act to say, "Here's what we suggest all municipalities put forward and deal with, not only in the municipal buildings but also in restaurants and in public places such as shopping malls"? What kind of enforcement will be used so municipal councils will feel they have to take the initiative and deal with it and give them the freedom to move ahead on that?

Around the municipality, we did a survey. Some have some bylaws related to their municipal buildings but usually have a smoking room that most of the time, we found, is not adequately ventilated to the outside. None of them have public smoke-free bylaws in place, in both Thunder Bay and in northwestern Ontario. Some workplaces do have policies, but usually common areas such as cafeterias are literally smoke-filled. An exception is one of our pulp and paper mills in the Fort Frances area that has been more aggressive and leads the way in

setting an example in that.

So we need stronger workplace bylaws, and in the act here a good model and example that will encourage municipalities to take the issue and move forward with a healthy public policy direction, as we've laid out in the province under the Premier's health council both in the present government and in the past government.

On that point, I'd like to ask that the committee move ahead and take leadership, as the province of Ontario can do and has the ability to do in spite of a lack of consistent direction on the federal side. We now have to deal with a greater epidemic. Just like discontinuing the hand-washing at the camp, we've got to move ahead with some more rules around preventive and promotional materials. Give us the teeth and public health line to lay in some rules and regulations around tobacco.

**Mr Tony Martin (Sault Ste Marie):** I don't think there's any doubt that the legislation in front of us today is going to pass. The question is what we will do to make it better.

What concerns me, as we sit here, is the same thing that concerns you: the bigger picture, the context within which we do this and the decision of the federal government and what that creates for Ontario, as we try to be good citizens, as we try to be in harmony with the groups you represent today in trying to reduce the consumption of tobacco products by pricing them at a level that makes them really not attractive.

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Over the last couple of weeks I've been trying myself to figure out how we do this. Ultimately, we as a government will have to make a decision. We're pushed into a corner where, because of what the federal government has done and our neighbours in Quebec, we will have not only contraband tobacco coming in from the States now but from Quebec as well. Access, even though limited by what we are doing re this legislation, will actually become greater, because it's going to be everywhere. It'll be out there at every corner in every corner store and all those kinds of things.

What advice do you have for us? Do we cave in? Do we drop the price so we keep the contraband out but therefore make it in fact more palatable for people to smoke because it's cheaper? Or do we hold the line and somehow try to deal with the contraband in some other way? I have to tell you, I'm at a loss.

**Dr Williams:** My first reaction is to block the rollback and hang firm, as Ontario can do, and lead the example in that line. The difficulty is, as in the analogy I gave, if you don't have any other strong reinforcement to hang on to, it makes it very difficult.

Bill 119, that we're trying to introduce now, probably should have been there five years ago. We should have been taking stronger strides towards bringing that into line, to say there's more. The cost as one inconvenience is one thing, but there's the inconvenience that you can't smoke in a restaurant, you can't smoke in a public place; that you find smoking in general is a custom and a habit that's not applauded by the public at large and you're made aware of that.

Even now they'll ask you at times at a car dealer, "Do you smoke?" and a non-smoker's car is cheaper. Make it a rule, for example, that cars no longer come with cigarette ashtrays: That's an option you have to pay \$500 or \$700 for, or you get a CD player instead of a cigarette ashtray—why is it standard? I don't know why it's standard any more—and that the resale of your vehicle goes down.

It's the same if you're going to have a restaurant that has smoking. Put in such stringent rules around air quality status checks that you'll have to put in a very expensive ventilation system to keep the air purified, and in spite of the heating cost you'll have to recirculate 50% to 60% of your air outside, and a lot will find that a difficult thing to move forward on.

If you're going to offer tobacco in that type of environment, you're going to have to pay the cost of that. I think the people will have to bear that cost rather than the students and the children who are inundated by this problem all the time.

Because you're dealing with the rollback on the pricetag and that's going to be a very difficult issue to deal with, the contraband, the fact is that we have to have firmer ones that will decrease the accessibility and also at the same time decrease the convenience of having tobacco, to protect our children and unborn children coming up.

**Mr McGuinty:** I appreciated your comments and criticisms of the federal government rolling back the tax and the consequences that will have in the long-term plan to reduce smoking, particularly among our young people. I am very concerned about what the Ontario government is going to do in the face of that. I suspect it's simply a matter of time before they roll back taxes in this province. I hope that won't be the case, but that's my suspicion.

There's a great deal of smoking going on in north-western Ontario. I'm trying to separate out the influence of tobacco companies' advertising and adults smoking. Do you know whether, if I've been raised by parents who smoke, relations who smoke, if I live in a community where it looks like, if you're an adult, you smoke—of course kids, as you know, want to look older. They want that independence and that freedom. They're not really into the responsibilities, but they want to look older. One of the ways you can look older is to smoke. Can we separate out our milieu as distinct from the advertising? If there all kinds of people around us smoking, am I more likely to smoke? It seems I would.

**Dr Williams:** I think they do play in together, having seen the effects in southern Ontario, and here we've delayed a lot further. The media and the marketing techniques are there. If everybody around you is smoking and from the age of zero up you're probably inhaling the equivalent of one or two cigarettes a day in secondhand smoke, it starts to bring in pre-addiction, and when you're under stress in the future—I am very concerned, and science will probably bear out in the time to come, that there is a pre-addiction taking place, and of course our youth are under a lot stress these days, and it's a stress reliever for a lot of people. Maybe we're unwilling



to admit the fact that our children are already pre-addicted in this process because of their exposure in that way. The more you're exposed to that, the more you breathe it all day long, therefore the easier it is, when you start to try one or two cigarettes, to say, "This really does feel good," and you start to get back into it very easily, that you're more susceptible to addiction and pick up on that. I think the local milieu is very important in this as well.

**Mr McGuinty:** I'm interested in your use of the expression "pre-addicted." If I'm a child and I have inhaled a lot of secondhand smoke, is it possible that I have developed a real addiction in the sense of physical need, a craving, for cigarette smoke?

**Dr Williams:** That's my jargon. As we measure levels of cotinine in the urine of the children, we know they've been exposed to levels of nicotine. What effect does that have on brain development, on the various centres? We realize that tobacco is a real addiction. It's not, as some say, just a dirty habit. All you have to do in northern Ontario is watch people at 35-below having to get out there for a cigarette. Isn't this an addiction? You better believe it is. It's the same with the youth who are out there their shirtsleeves, out of the school, standing on the edge of the property 200 yards from the door of the building. You've got to be addicted, you've got to want it.

**Ms Carter:** You certainly made a strong case for northern Ontario having a higher problem than the provincial average. What effect do you think this federal tax rebatement is going to have on the availability of cheap cigarettes here and the problem it causes?

**Dr Williams:** Manitoba still is holding on, so I don't think across the border on that side will be the issue. There is still across the border on the American side. If the province rolls back the taxes accordingly, it will make it much more accessible. I indicated here the number of families that are low-income that are smoking. It seems we have a high percentage because our average level is not the same as it is in southern Ontario. I think that will be a main factor for those who were thinking of quitting. There have been a lot who've quit who say, "I just can't afford it any longer." That has really added teeth to the programs, whatever method you want to use. The same will happen with the youth with that rollback, because there's less of an incentive to try to quit because they need the money for those other things—the date, whatever they want to go on.

We have to wrestle with the fact we may have to put in patch programs or whatever in high schools, because already you have to start a discontinuing program in grades 9, 10 and 11. It's a sad state of affairs, but we may have to seriously consider that.

**Ms Carter:** I was interested in your statement that environmental tobacco smoke can be addictive. I remember as a kid being in smoky rooms and feeling bad, having itchy eyes and a sore throat and a cough and so on because of it. Is there any scientific proof that it can actually encourage people to become smokers?

**Dr Williams:** No. It's difficult. How can you prove measurements of addictability even in the adult, except I

have it in behaviour? The adult who is addicted has high levels of nicotine and the byproducts in the urine, and if you take the fact that an American study in the New England Journal late in fall 1993 found elevated levels of cotinine in those children with passive smoking, they've obviously been exposed to nicotine. How do you measure addictability? It's a very difficult thing to say, except maybe with a good prospective study, and that would take a bit more work: Of those who have been exposed to a lot of secondhand smoke, what is their uptake of smoking, more or less?

If you look at northern Ontario, do our children in the north have greater peer pressure than those down south? I doubt it. I think they have the same peer pressure, the same stresses, the same exposure to marketing. But they have a lot more exposure to secondhand smoke, by looking at the stats and data, than kids in southern Ontario. It may be relevant, but to say it's a hard scientific fact—I don't think anyone has that kind of research methodology to prove that except by a prospective study. That would be good work to carry out.

**Ms Carter:** It's also part of a message that smoking is normal and this is what everybody does. Does that exposure of so many youngsters to environmental smoke have a measurable effect on general health levels, on the number of kids who are getting chest problems, or whatever?

**Dr Williams:** I've been trying to follow this along over the last two or three years. I've had complaints from many teachers wondering why there's an epidemic of these things showing up in the schools. They say it just seems to be escalating every year by leaps and bounds. I would like to do some studies to see what is the percentage and do some comparison over years.

Most of the paediatricians will comment that they don't know why they have so many children around who have very irritable airways that require, even after a cold or minor things—I remember this as a kid myself, that before this was diagnosed, my cold would go on for almost three to four weeks and I'd have to have antibiotics every time. I now know that if I take my inhaler at the right time when I'm in a smoky environment, I don't have to resort to that. A lot of the children weren't aware of that in my day, and now they are.

There are a large number with asthmatic or asthmatic-like conditions who have very irritable airways. As result, it seems like every kid's walking around with some of these in the schools at times and Epipens are everywhere.

**Ms Carter:** I've heard the same thing in my own area, that large numbers of kids are using inhalers.

**Dr Williams:** I can't say it's purely due to smoking only, but I'm very concerned.

**The Chair:** Dr Williams, thank you very much for coming this morning and for your presentation.

1110

JENNIFER PAXTON

**Ms Jennifer Paxton:** I am Jennifer Paxton, a 15-year-old grade 10 student at Sir Winston Churchill Collegiate and Vocational Institute in Thunder Bay. I'd like to thank all of the members of the standing committee for coming

here today and hearing our arguments and our ideas on the passing of Bill 119. It takes everyone's time and effort to get it passed, and it's a large commitment. We need it to be accepted into society, because smoking stinks.

Although all aspects of Bill 119 are important, I feel strongly on two aspects as a teenager, because I have two parents who smoke and friends who smoke. I'd like to see them have a challenge put up against them, that they have a harder time getting tobacco. It's too easy for them to walk into a store and purchase tobacco products. I've discussed it with a few friends and even they find it too easy to walk into a store and just ask for a package of X brand smokes. They just get them, no problem.

The two aspects of the plan I'd like to talk about are the plain packaging and the licensing of stores to have more control over who is purchasing the tobacco.

The plain packaging: It's common knowledge that colour and looks sell a product, like jeans. If they look good, people will buy them. Cigarettes: If the packages are bright, the designs are good, people are going to buy them. They catch their eye; they buy them. Plain packaging should be regulated, because then it makes the packages look dull and dirty and people will decide they don't want to be seen walking around with the packages. They're more likely to keep them hidden or even not buy them because they don't catch their eye. They don't want to pay for something that looks dull.

As a teen, I see people going around flashing colourful packs of cigarettes, feeling they are cool and more popular because they smoke cigarettes. If it is made so that tobacco companies are forced to have dull-coloured packages with health warnings on all sides clearly visible, it will have a definite effect on the teens who are considering taking up this habit. They will see how ugly the packages are and it will make them less eager to be seen with them.

Younger children, when they go into the drugstores or the corner stores and stuff like that, see the small packages behind the counters and figure that since they see their friends and relatives walking around with them, if they've got them in their hands they'll be cool, they'll feel older, more responsible, whatever. If they're bright colours, they tend to see them more than if they were dull packages with no designs on them. It's just like pieces of cardboard. They don't want to buy them, no interest. It's kind of like hockey cards—same effect—in the packages. They'll soon realize how much of a social outcast smoking is and eventually they'll change their ways, I hope.

Enforcing the new plain packaging will result in more children deciding they'd rather not buy the cigarettes because of how ugly they appear compared to the eye-catching packs you see nowadays.

Smoking has an image of being fun; it makes you look popular. If smoking gets an image now, if the bill gets passed that plain packaging can be regulated, it'll just change the image totally.

Whenever you go to sporting events or hockey games you look around the arena and see advertisements for

Player's Light, Rothmans, du Maurier all around the rink. That's giving the image to the people watching the hockey games and stuff like that that smoking is all right. If it's at a hockey game, that means the athletes will be smoking, and if younger children see the athletes smoking, they think it's all right for them. It'll make them stronger, better players of hockey, football, whatever sport it is they're watching.

If you look at the posters, the banners or whatever, they are the same colour as the packaging of the cigarettes; they are related. If the packages are plain-coloured, there will be no relation between the banners at the sporting events and the packages of cigarettes, making it harder for the younger children to determine which cigarettes, because there's no colour to relate them to.

The second point I would like to stress is the licensing of stores that sell tobacco products to minors. It is way too easy for students to go into a store and buy cigarettes. I've said that before, but it can't be stressed more. My sister's in grade 7, so she's 12 years old. She can easily walk into a store and request cigarettes. You saw Ryan today. He went into 10 stores and he managed to purchase eight packages from the 10 stores. It was so easy, he just walked in and asked for them. They didn't ask any questions at all.

Making it so that a store must be licensed to sell tobacco products would make their owners more reluctant to sell them. If when they are caught they must pay the consequences, ie, losing the privilege of handling tobacco products and therefore losing the profit of selling the product, that would be good because they would be more reluctant to sell to a minor without asking. I'd say a good idea would be asking for an age of majority card because then you automatically have proof of how old the person is. If they don't have it and the storekeeper is caught selling tobacco products to a minor under 19 years old, he can be charged or lose his privileges of selling it. If he does that, he is losing the great profit of selling tobacco even to those over 19 in the community. I feel they would recognize this and, instead of selling to a small minority of children under 19, instead of losing the profits from all of them, just lose the ones from the minors.

To summarize, it is too easy for teenagers to smoke— young children, teenagers, all alike, it's just too easy. Tobacco is an addictive substance. At the young age children are beginning to smoke, they just look and see other people doing it and they figure, "They're doing it." They don't realize it's addictive when they start, but later on, after they are addicted, they cannot break away from it. They do not realize what they've done earlier. They're too young to make the decision for themselves.

If these issues are passed in Bill 119 and we limit the access to children under 19, minors, we limit their desire to smoke. We turn them off it. I have no will to smoke. I hope my friends will not start smoking. I'd like to see my parents quit smoking because it just—it stinks. I'd like to convince them not to. I've tried, but they've been addicted to it since they were little and there's nothing I can do about it. I'd like to try stopping my friends from smoking if I have any say in it. If they ever say anything



to me, I try to get them not to.

I guess that's it.

**Mr Ron Eddy (Brant-Haldimand):** Thank you, Jennifer, for coming before the committee with your views. It's really important that the members of the committee hear from students at our elementary and secondary schools on the tobacco issue and on the bill. The bill will do some things, and any suggestions you have to strengthen it are very important as well.

Across Ontario the availability of smuggled cigarettes is very apparent, to the extent that people buy them and sell them singly, we understand, in some school yards. There's also the problem that some tobacco manufacturers are making kiddie packs of, say, five cigarettes. The reason of course is they're much cheaper and they get people involved in smoking. Do you find those problems in the north as much? We know they are prevalent in parts of Ontario, but are they around in your area as well in schools?

**Ms Paxton:** I've never heard about any problems with smuggling around my school or anything like that. I know they'll purchase kiddie packs because they're cheaper than the regular larger packs. Quite a few students will buy them, or they'll split packs. They'll buy them in a group and split them up and divide the costs among themselves.

**Mr Eddy:** Do you feel strongly that the kiddie packs should be banned absolutely as well?

**Ms Paxton:** They should be banned because it just makes it easier to get them. It's cheaper; they still get cigarettes.

1120

**Mr Carr:** Thank you very much for a great presentation. I was just wondering if you knew, among your friends, where they're buying. Are most of them buying them legally, illegally? How are they doing it?

**Ms Paxton:** I know of a few stores around the school and around the area that they can buy them from, or they get their older friends, older brothers and sisters to buy them for them.

**Mr Carr:** Is cost a factor to them? We heard young Ryan talk about how even at his young age they've got enough money. How much of a factor is the cost? They're fairly expensive and they're still able to do it. The cost is not a factor, I would say.

**Ms Paxton:** Some of my friends have jobs so they figure, okay, there's their money there. They buy smokes instead of gas for their car or whatever else they need. There are people I know who go around and bum cigarettes, to use that term. They go around asking people they don't know or friends they know for cigarettes or they buy them for quarters or stuff like that.

**Mr Wiseman:** I really appreciate hearing from you and from Ryan this morning and the other students we've heard, as this bill is directed at trying to prevent young people from smoking. In terms of peer pressure, what would be the single most important pressure that would cause somebody to smoke or to not smoke?

**Ms Paxton:** They see all their friends doing it. They

think they're the only ones out, that they're not cool enough to hang around them, so they start smoking to try fitting in with the group.

**Mr Wiseman:** There has been some suggestion of an advertising campaign showing a big table with the owners of the tobacco companies laughing—all the way to the bank, by the way, because the profits are huge—and a message saying that young people are being duped and that they are being used to make huge profits for these companies, and of some powerful imagery, maybe even sitting around a coffin, laughing and celebrating their profits, with young people dying. We actually had presentations where somebody young, in their early 30s, who had been smoking for 23 years was dying of lung cancer. Do you think young people in your age group would respond to the fact that they're being used?

**Ms Paxton:** I think they would. It's their money that they're spending, and instead of spending it on cigarettes and getting these people to sit there and laugh at them, they can be using it on things they'd rather do like going to the movies and buying things they'd rather have than cigarettes, which only lead to death. They don't get anything from it besides sickness.

**The Chair:** Thanks very much for coming before the committee.

#### CANADIAN INSTITUTE OF PUBLIC HEALTH INSPECTORS, ONTARIO BRANCH

**Mr Michael Reid:** I'd like to take this opportunity to thank the committee and the government and the opposition parties for making this opportunity available for us from the north to make our presentations. I almost feel like I should be introducing myself as, "Hi. My name is Michael Reid and I'm an ex-smoker," which I am. I'm also a public health inspector with the Thunder Bay District Health Unit, and have been for 28 years. I am the Ontario branch president of the Canadian Institute of Public Health Inspectors. There are over 600 public health inspectors in the province, all of who are, as I point out, qualified to be named the inspector, if you will, named in the bill.

We do a variety of other things besides the role of provincial offences officers. A number of those are education, health promotion, and sanitation inspection in a variety of areas. A smaller part of our job, and I would like to stress this, is the role of the provincial offences officers. We certainly are more interested in, through education, having people do things the way they should be done rather than coming down on them with a heavy hand. I would also suggest that when this bill is made law, the educational aspect in dealing with those people who sell tobacco products is put foremost, before you come down with a heavy hand on them.

We also believe there's no reason for the province to create a new cadre of inspectors in the province, because we are already there. We have the background, we have the expertise to do the job. There will be costs, of course, because this would create an added workload to the health units and the public health inspectors now doing the job, but nowhere near what it would be if you had to gear up a new branch of inspectors or even, as the suggestion was made, turned it over to the Liquor Control

Board of Ontario and had their inspectors do it. I think they have two inspectors for the whole of northwestern Ontario, which certainly would be inadequate for the job.

I would also suggest that the institute is in a position to bring public health inspectors in the province up to speed with the new act to have them ready to enforce this act. We have some expertise in this matter, inasmuch as we have dealt with the Ministry of Health as a cooperative partner in putting forward the Hazard Analysis Critical Control Point Protocols manual and have used the "train the trainer" aspect in passing that information along to public health inspectors throughout the province. We're also at present engaged in another joint venture with the ministry for a healthy environments mandatory program. So we are not without a certain amount of expertise in dealing with this whole matter of education as well as the enforcement aspect of the bill.

That's all I have to say at the moment.

**Mr O'Connor:** My question is around licensing. We've heard a number of presentations, especially in light of what the federal government has done. With the Liberal government lowering the taxes, we've heard more loudly and more vocally about the need for licensing. I just wondered if you have any experiences with licensing, because currently municipalities do have that ability and some have actually gone about putting that in. Have you had any experiences within that type of licensing system?

**Mr Reid:** Yes, we do. Certain municipalities do have bylaws that state that an establishment, whether a restaurant or whatever it happens to be, cannot get a new licence unless they have been inspected or have a letter from the health unit stating that there's no reason for them not to get their licence. There would be a control over that, and that assures the municipality and the health unit that these places have been looked into prior to a licence being approved. It's also a method of making people do what you want them to do, if you will, by withholding their licence, which means they can't operate, and which avoids court and that sort of thing.

**Mr Jim Wilson (Simcoe West):** As you point out, section 13 of the act says the minister "may appoint inspectors for the purposes of this act." It's been suggested to us that "may" should be changed to "shall." But you also point out, and I think it's an excellent comment, that the province shouldn't be setting out to create a new cadre of inspectors. To the best of your knowledge, have there been any discussions with the government about who these inspectors will be that are envisioned in Bill 119? Are you aware of any discussions in that regard?

**Mr Reid:** No, I'm not. In my comments, if I heard you right, I'm suggesting they don't have to. We can do it. In December, I wrote the Minister of Health suggesting that we were definitely for Bill 119 and that we were more than willing to step in and fulfil that role.

**Mr Jim Wilson:** Did you get any response from the Minister of Health to your letter?

**Mr Reid:** No, I haven't.

**Mr Jim Wilson:** Here's your opportunity. Perhaps the parliamentary assistant could tell us what the government envisions with respect to who the inspectors will be in

this bill.

**Mr O'Connor:** It's my understanding that the Minister of Health already has gone on the record that we would be looking to the public health inspectors to carry out that role. I guess you've heard it again today. I appreciate what you have presented to us and anything you might want to add.

1130

**Mr Reid:** I'm also saying that our institute has the expertise to be well involved in this, and the ministry probably is aware of that because of our involvement with it in the past in what we have done as well.

**Mr McGuinty:** To pursue this a little further, this will mean an increase in your workload, quite understandably, as you mentioned. What would that mean? You are responsible for a certain area?

**Mr Reid:** Yes, we are. I can read off a list of the various things we do, but we basically look after a certain amount of health promotion activities in terms of the Foodsafe program, rabies programs, communicable diseases. We run food handlers courses, as well as put in the HACCP protocols in inspections we do in the high- and medium-risk restaurants. We spend time on various committees, and we are fairly busy, but a lot of the times we go by, walk by and drive by, the places that sell tobacco, so it would be a matter of a little deviation to handle it.

But that's not in all cases, of course, because a lot of the health units are fairly busy. What with the social contract and the tough times, people have been laid off, and health units are stretched to the limit at the moment. As I say in my brief, there's no doubt that the government's going to have to put some money into it, but not anywhere near the amount of money it would have to put in if it wanted to start from scratch.

**Mr McGuinty:** How many people are employed in your unit and how many more would we have to hire to ensure they could carry out the provisions of Bill 119?

**Mr Reid:** We have six public health inspectors in Thunder Bay who cover Thunder Bay and area, and we have two health inspectors—one lives in Geraldton and I live in Schreiber—who look after an outlying area. I really couldn't say, until we get a finalized look at the bill and find out exactly what's going to be involved. I would think initially, if we do it the proper way and go out and do some educational work on it, that would take more time and more staff to do. I think that's an integral part of making sure that once the bill is enacted, it's put into force properly rather than just fanning out and nailing everybody.

**The Chair:** Thank you very much for coming before the committee today.

LAKEHEAD ELEMENTARY ADMINISTRATORS

**The Chair:** I call Laurie Margarit of the Lakehead elementary school administrators' association. Welcome to the committee. I can see there are two people here, if you would be good enough to introduce yourselves.

**Ms Lise Haman:** Neither one of us is Laurie. Laurie Margarit is in the audience. My name is Lise Haman, principal of Pine Street School, and this is Peggy Mason,



principal of Claude Garton School, here in Thunder Bay. We represent the Lakehead Elementary Administrators.

The association is comprised of approximately 80 vice-principals and principals of elementary schools in the Lakehead Board of Education. We are committed to ensuring that our young people are educated and well informed to make wise decisions for their future.

In looking at the bill, the people it affects most are the young adolescents. Just as we plan our programs in schools based on the needs of the children and their stages of development, it's essential for us to take into consideration what the needs of the adolescents are and recognize what those are and ensure that the bill addresses that.

First of all, adolescents have a need to assert their individuality and their independence, to the point where they will defy rules. The other thing is that they are very insecure; they need to prove to themselves, prove to other people. In order to belong to groups, they'll experiment with drugs, with cigarettes and so on. They need to feel glamorous. The most important thing is that they feel they're invincible.

We're pleased to see Bill 119, and we applaud the government for leading the way across the country. The messages I believe Bill 119 is sending are strong and consistent with our mandate with regard to educating children about tobacco.

It's been proven in many studies that the partnership between parents and children has a very strong impact on the success of children. Therefore, we encourage parents to become involved in their children's schooling. It is also essential that the government, educators and health agencies become partners to make sure we can have an impact and influence young people in the province.

Therefore, we feel that the government's role in this particular case is legislation. We support the government in eliminating vending machines, and the message is strong; raising the legal age; prohibiting smoking in public places; prohibiting the sale of tobacco in health outlets, be it pharmacies or other agencies; and ensuring that the laws are very strong, have the strength of, for instance, the alcohol laws. Teenagers aren't allowed to drink before the age of 19, and we should have the same very strong laws with regard to tobacco.

**Ms Peggy Mason:** I thank you as well for the opportunity to speak. Among the adolescents that I deal with, there are often several who are addicted to tobacco by the time they reach grade 6 and will admit that to me as a principal when I talk to them about not smoking in the school yard. You get to see that these drugs reach students very early. A lot of it has to do with the influence of their peers and what goes on in the home.

We as educators have proven that by working with students in group situations that have discussions, that have activities where kids have to talk about the effects and hear what the other children think about smokers, it gives them a chance to work it through before they are faced with the choice about: "Do I try this? Do I take the chance to be hooked?"

The campaigns that have gone on in schools and in the

media about drugs depict people that use drugs almost as losers, and they also show a lot of the physical damage that gets done. We need to tackle that part of the adolescent that believes they're invincible. I think they believe it till they're 25 or 26. We have to reach them so they know that down the road they're going to pay a high price for getting involved in smoking.

I don't think these materials—we have some right now from the cancer society and the lung association that have been used in our schools, and many boards have developed their own. They need to be revitalized so they have the maximum effect. We need to have more group activities, and there just needs to be a few lessons that every single classroom in this province would receive. Some of the posters that get distributed to schools are excellent. When you see the beautiful young teenager turn into a withered lady, that hits girls right away, because they really want to feel that this isn't damaging them.

**1140**

Some of the materials could be developed at a reasonable cost and could be directed at what goes on at the classroom level for teachers so they can work with students and have children work their way through this. It's not doing a lot of research projects; it's actually coming to terms with "what the effect on me will be."

The legislation that makes these drug sticks difficult to get will be helpful, but we also need to help kids make good decisions. Those students who have seen the reality through things that have happened in their family make the right choices. When they really come face to face with what happens to you if you become a long-term smoker, they don't touch those sticks. That's what we need to get out to students. They are smart and they are reasonable, and when they work through this together, I think we can have much more of an impact.

So I thank you for leading the way and working through this legislation. With messages that come from the media, from the government and from educators, I think we can do a better job of raising a generation of students that maybe is not hooked and lives a healthy lifestyle.

**Mr Jim Wilson:** Your observations about young people are consistent with what young people have told us themselves. In fact, we had a group of five or six young smokers appear before the committee a week ago. They essentially said what your observation is in the first part of your brief, that it's sort of a thing you have to go through, that yes, they are defiant and smoking is a trial-and-error thing and kids have to figure it out for themselves. They said: "It really doesn't matter if you raise the age to 19 or whatever or put \$100,000 fines on retailers. We'll get the cigarettes and we'll smoke."

You mention the alcohol model and how we treat alcohol in our society. It seems to me that perhaps we should put some responsibility on young people themselves. There is a model in the United States where they have a licensing system but also the kids are fined \$25 for being in the possession of cigarettes or smoking under a certain age. Do you think that would work?

I asked the young persons who appeared that day, and one felt it might work; the other ones weren't too sure. But they were very much aware of the laws with respect to alcohol. They knew they weren't to consume alcohol under the age of 19 or some of the other laws associated with that. What's your opinion on that? Would it go towards helping to eliminate them taking up the habit?

**Ms Mason:** The norm you were talking about, of students realizing it isn't acceptable and that's why the age is higher, I think that's a healthy norm: "It's not acceptable for you to be smoking, and that's why we have age restrictions."

As far as the fines and the law are concerned, I'm not sure. I don't know what the research shows about how it has affected the students in other places. I agree with what you're saying about them becoming responsible, and that's why I think we need to give them enough information that they can see what the effects are and make wise decisions, because if they tinker with it for too long while they're young, they're hooked, and some of them are hooked in a very short time. One grade 6 girl told me that it was just a few months, and she's having an awful time right now with the pressure of her friends and her own addiction. We've worked through some of that with her.

**Mr Jim Wilson:** It's quite sad. We consistently hear the stories of young people as young as grade 6 addicted to smoking. It's been an eye-opener for me, I must admit, because I recall kids trying cigarettes in grade 9 and grade 10, maybe grade 8, but I don't recall as low as grade 6. It's quite a shocker.

Can you give us a brief outline of what educational materials are available now in the schools?

**Ms Mason:** There are kits that the cancer society and the lung association have put out. They are packages that have some lesson plans in them, and posters. Our board has put together materials, and I'm sure many boards in Ontario have put together materials as part of the peer pressure programs, whatever the titles are, within their boards.

When Lise and I were talking about what we think might be helpful, focusing on the information we have available to us now, these materials are at least 15 years old, so things need to be revitalized and updated and made more powerful; also employing strategies that have students talk and discuss because the influence they have on each other you just cannot imagine—it is so strong. If those kinds of activities were updated, the material would be much more effective.

**Mr Jim Wilson:** Is there a mandatory requirement to teach these materials in the schools, or just up to individual school boards?

**Ms Mason:** Individual school boards.

**Ms Carter:** I was very interested in the educational side of your presentation too. You already answered one question I had, which was, should we emphasize that smoking doesn't go with beautiful, attractive people, but goes with wizened, dried-up, withered, sick ones? You're obviously doing that. Do you also get across to kids the message that they're being exploited, being suckered, that

somebody is out to take advantage of them at their expense?

**Ms Mason:** That's one of the features we'd incorporate into a new campaign. If there are teachers doing a good job of teaching students about media and how media can manipulate, which is part of the Ontario curriculum, I think that would be happening, but perhaps it's not directed towards just the topic of smoking. We could integrate that and make sure it focused on how you're being drawn in to smoke and who's really benefiting from all of this, that yes, you're being used.

**Ms Carter:** It's as though we never target anybody as being to blame, that we're just conducting campaigns in a vacuum and disregarding the fact that there are people out there who are deliberately out to hook kids on nicotine and make a profit out of that. There's nothing cool about being taken in and being suckered. I would have thought that, in addition to the fact of what it does to you, would also be very powerful. I hope you would use that.

**Ms Mason:** It might be difficult to put that into an advertising campaign, but it certainly could be part of the activities you have children explore: Just who is benefiting? How are they benefiting? How do powerful groups lobby? How do you get some of these decisions made by governments? They're very powerful lobbyists, and that's something the students don't realize.

**The Chair:** Thank you both very much for coming before the committee today.

Committee members, before we break for lunch, the parliamentary assistant wants to raise one issue for clarification.

**Mr O'Connor:** We've had, on occasion, some discussion around possession and the role of young people, and there are some legal implications about some of the choices and positions we have heard. I ask legal counsel Frank Williams to come to the microphone and give us a few of his pearls of legal wisdom.

**Mr Frank Williams:** I just want to make it clear that I'm not making any particular recommendations to the committee, but I thought this would be a good opportunity as several presenters and several members of the committee have raised the issue of possession by minors.

I'll just outline briefly how the Young Offenders Act and the Provincial Offences Act affects minors and in essence how the court sentences.

On the issue of sentencing, it's worth noting that community service is something the court does in lieu of sending somebody to prison. Community service as a first step in sentencing is not the way the courts work; it's in lieu of imprisonment. Likewise, imprisonment is in lieu of where somebody doesn't pay a fine, so it's a three-step process. So in terms of the suggestion that perhaps community service should be the punishment for a young person, although I admit in a philosophical vein that would be very laudable, that's not how the court works. Likewise, imprisonment would have to come as a first step before you'd have community service being offered as an option or an alternative to imprisonment.



Having said that, how does that work with the Provincial Offences Act and the Young Offenders Act? The Provincial Offences Act, first of all, prohibits the court from convicting anybody who's 12 years of age and under, so if a young person 11 or 12 was caught with cigarettes there's no punitive sanction the court could offer. It's prohibited from convicting a person under 12 years of age.

Between the ages of 12 and 16, the court cannot offer imprisonment as an alternative, say, to payment of a fine. If a young person refused to pay a fine, should that be the penalty in the statute, the court couldn't then say, "Let's put community service in place of imprisonment." There's a limit between 12 and 16, which leaves another age group of those older than 16 and those 19 and under. People that age would be treated the same as adults.

The complicating factor in all this is that you've got three different age ranges and each would be treated differently by the courts. I just want to put some perspective on that when you're considering what recommendations you want to make in this regard.

**Mr McGuinty:** We explored this on the committee which dealt with the bicycle helmet legislation. At the end of the day, the law was passed that does make it illegal not to wear a bicycle helmet at some time down the road. There is a minimum fine. If you're 13 and you're not wearing your helmet, you'll be subject to a minimum fine under the Provincial Offences Act, in the range of \$70 or something like this.

**Mr Williams:** What I am suggesting is that you could fine somebody who's 13 and older but you couldn't impose a fine on somebody 12 and under. I'm not that familiar with the exact sections of that piece of legislation, but perhaps there's some way of having the parent pay the fine, I don't know.

**Mr McGuinty:** You make reference to imprisonment. I'm sure nobody here wants to throw a young person in jail for having tobacco products in their possession. If you are fined under the act and you can't pay the fine, what happens?

**Mr Williams:** Under what statute?

**Mr McGuinty:** The Provincial Offences Act.

**Mr Williams:** In respect to a young person? I don't know, to be quite honest with you. I don't know if there's any further consequence. I guess it ends there.

**Mr McGuinty:** There's been general movement—I've read a few articles in the paper recently—to get away from this idea of putting people in prison because they can't afford to pay their fines. Anyway, thank you.

**Mrs O'Neill:** I want to go to another part of the act while the legal counsel is here, or maybe the parliamentary assistant should answer this. I've had several questions about paragraph 1, section 9, regarding the exceptions or exemptions. Could someone help me understand just what that means or what kind of areas we're talking about? I would appreciate a clarification.

**Mr O'Connor:** This would be the area which would allow us to do some designations within health facilities.

**Mrs O'Neill:** Are health facilities the only area that

part of the act would cover?

**Mr O'Connor:** If we move down to paragraph 9, that gives us the ability to prescribe other places.

**Mrs O'Neill:** Have we any ideas of the areas the government's going for that? Have you got a list in the back of your minds?

**Mr O'Connor:** Not at the present time, but any areas committee members would like to suggest—and we've heard some recurring ones that are pretty obvious that people would like to see us move in. I'm open to listening to areas any committee member would suggest be included as we prepare to make the regulations later on this spring.

**Mr Eddy:** I'd like to ask about subsection 3(1): "No person shall sell or give tobacco to a person who is less than nineteen years old." There's no barrier to including a parent or a guardian in a family home, a parent who gives a child a cigarette? There'd be some very interesting situations, I'm sure.

**Mr Williams:** I agree with you, there's no barrier, but from a practical point of view, it would be very difficult to enforce in terms of a parent giving a child cigarettes at home. We're not going to have people breaking down doors to see if people are giving their children cigarettes. From a practical point of view, I don't know how that would work, but certainly in theory the law says you can't sell or give to somebody 19 years of age.

**Mr Eddy:** That includes parents?

**Mr Williams:** That's right.

**The Chair:** I remember an interesting case in Niagara Falls, I think it was—this would be 15 years or so ago—where a policeman walked by a house and saw a father giving an underage son a drink and the policeman went in and charged him. I can't recall what happened in the case, but it was as you described, somebody giving a person who was under age a drink, which was unlawful. It would be an interesting case.

Just before breaking for lunch, because we have to be back here at 1:30, there are several tables at Timbers that have been reserved for us. I also remind members to check out. You can either leave your bag at the desk or in Mr Arnott's room, whichever you prefer.

With that, we stand adjourned until 1:30.

*The committee recessed from 1157 to 1330.*

#### TOBACCO FREE THUNDER BAY

**The Chair:** Our first presenter this afternoon is the representative from the Thunder Bay tobacco free committee. Would she be good enough to come forward. I take it by a process of elimination that you are Sophie Wenzel.

**Ms Sophie Wenzel:** That's correct. Jean Juneau has to give his regrets today. He was unable to attend.

**The Chair:** A copy of your written brief has been circulated, so please go ahead once you're settled.

**Ms Wenzel:** I'd like to introduce myself. I'm Sophie Wenzel, and I'm the lung association representative for Tobacco Free Thunder Bay. Tobacco Free Thunder Bay is a regional coalition and it's made up of a number of organizations within the Thunder Bay district. We have

our lung association, the Heart and Stroke Foundation, the Canadian Cancer Society, the Cancer Treatment Centre, the Addiction Research Foundation, the Thunder Bay District Health Unit, Ogdan East End Community Health Centre and the RCMP. I'm not sure if I've left anybody out but they are listed on the cover page of the submission. We also do have individual representatives on the coalition as well.

As the name suggests, Tobacco Free Thunder Bay would like to see a ban on all tobacco products by the year 2000, but depending on the time lines, whenever it comes about, we would still be happy. We do realize we have to start somewhere and we have to applaud you for Bill 119. It's an excellent start to this. We applaud the government for introducing it and the opposition parties for supporting it this far, and for everybody being out here today to listen to the opinion of the public.

We've outlined a number of things that we'd like to see just as amendments and some additions to the legislation in the submission. Due to time restraints, I'm only going to talk about the packaging requirements, the plain packaging, the ban on kiddie packs and the licensing that we'd like to see included.

As you can see here, I have the packages that were obtained by our 12-year-old, Ryan Fitzpatrick, this morning. You can see they're all in different designs and different colours and they're very intriguing. If you look at them, I don't know if anybody from there can actually read what the health warnings say on here. If you can, could you please read them out, the exact wording. I'd be very interested to know.

You can see how the packaging is used as a tool, not only to advertise but also to hide the health warnings. If you had the plain packaging it would be very prominent, because they'd all be the generic white or the generic beige packaging and they'd have the same postscript for the titles, and then the warnings would stand out much more. That's one of the arguments why we would like to see plain packaging.

The other reasons are, more important, that the packages themselves are advertising. They're pulled out of pockets every day, they're set on tables every day by parents, by teachers, even sometimes you have athletes with them out there, and that's not giving the proper message to our children. So it would take away the advertising that the packages themselves have by including plain packaging.

As well, it would also stop the sponsorship that's being done by the tobacco industry, because if everybody has the same package, you won't be able to diversify between the brands.

Finally, it will help to diversify between the domestically sold and the smuggled cigarettes. Obviously, that is an issue right now. It would be a good source which would be even more prominent than a yellow band around it or the gold one. It isn't very prominent.

The other thing we'd like to see is a ban of the kiddie packs. We all know that kiddie packs, the 15 packs, have been targeted right to the children, because they don't have excessive amounts of money readily available to

them. When I go out into schools and I make presentations to the children, when we're talking about quitting smoking, the first thing we ask them is: "You can save money by quitting smoking. How much is a pack of cigarettes today?" They always say \$3 or \$4. It's the older children out in the high schools who will say \$7. This just shows you right there, when 90% of the children are saying \$3 and \$4, that's what they're purchasing, and that's because that's who they're targeted to.

We all know that the price of cigarettes and the consumption of cigarettes are inversely related. According to various studies, for an adult, the elasticity is negative 0.04, which means for a 10% increase in price, there's a 4% decrease in consumption. The estimated elasticity for children is negative 1.04, which means for a 10% increase in price, there is a 14% decrease in consumption. So it's very important that kiddie packs are banned.

In order to include this in the packaging requirements, it should be specified, for example, that the minimum number of cigarettes to be contained per package is 20 cigarettes. In that way, we will eliminate these kiddie packs that are targeted towards the young people. So we recommend that the banning of kiddie packs as well as plain packaging be specific requirements within section 5, packaging requirements.

The other thing we'd like to talk about, with the tobacco tax rollback that has happened recently, is licensing. We feel now with the rollback, it's really important that we do have licensing. What we would like to see with licensing is that each vendor who is to sell tobacco is required to purchase a licence. The licence would be suspended from the vendor each time he violates Bill 119. For subsequent violations, there's a longer suspension, and say after three or four violations, you could permanently revoke the licence.

The benefits of licensing would be that it would deter vendors from selling to people under 19 years of age, because not only would they lose their tobacco sales when they lose their licence, but they're also going to lose the spill-off sales such as the milk and the bread that people come into the store to buy when they happen to be stopping to buy their cigarettes.

Secondly, with a fee being charged for the licence, it would be self-financing. It wouldn't come out of taxpayers' money, it would already be there, the money from the licences. So you can use proper enforcement for it as well.

Thirdly, it would act as a record of who is selling tobacco. You would already have a record of who has licences, that is, who is selling the tobacco, and it may make your reporting a little bit easier.

Finally, with licensing, it would also keep away from a backlog in the court system.

Just a final comment I'd like to make is that enforcement is very important with the legislation. It's an excellent piece of legislation that you have introduced and supported. Now we need to hear from you what the enforcement system is going to be, because that's what will make or break a bill as well.

We had a couple that were here this morning and they



just asked me if I would come up here and let you know that they have a granddaughter who they found out is smoking. One of the persons, the grandfather, is in a group called the short-of-breath group. He has either severe asthma or emphysema, the diseases such as emphysema that are related to smoking.

He said: "Will you please tell them that children think they're invincible. They need the government to tell them they can't smoke. When they're old enough to make the decision, that's fine, but when they're that age, their response to what's happening to older people is, 'Well, they're just old,' and they think they're invincible." They wanted us to pass that message on to you. That's the thinking they're getting from the children, and something should be done by the government. Thank you.

**The Chair:** Thanks very much. That sense of invincibility, as we know as we get older, we all recognize that we're not quite there. Thank you for your submission.

1340

**Mrs Haslam:** I'd like to go back to the licensing idea, because the model that is now being suggested is fines. If you're caught selling to a minor, there is a fine process. If you're caught with two infractions or three infractions within a five-year period, you would lose your right to sell tobacco. Tobacco would not be allowed on your premises. You couldn't even store it in the basement of your store. It has to be totally off your premises.

The manufacturers would be informed in written form that they were not allowed to sell tobacco to your store, because you had been targeted as someone who had broken the law. You would have to post signs saying that you are not allowed to sell tobacco. The reason for that would be very clearly indicated right there for all of your customers to see that you had been caught selling to a minor. I wondered if you still felt, with that model, that licensing was preferable to what was being suggested in the legislation.

I think the concern is that for a lot of small businesses, it's very time-consuming to set up that type of practice. It's not quite so time-consuming, because there are already investigators out there who can automatically now go in and investigate. We could use the money to increase the number of people doing it, rather than putting all of that money and effort into reinventing the wheel for this particular issue.

Are you still in favour of, it isn't more stringent, but the different way of licensing that you have indicated here?

**Ms Wenzel:** I think I am in favour of the licensing. I feel if the person could permanently lose their licence, that's even more of a threat. We have children saying to us: "With the legislation, if you increase the age to 19, it's not going to make a difference. We'll just go into the stores when our friends are working." If they're risking losing that licence permanently, then they are going to make sure that the people selling the tobacco abide by it.

**The Chair:** Could I just ask you one question that has come up a couple of times: What evidence do you have, anecdotal or otherwise, about the smuggling problem here? Is it less up here than it is in areas to the south, or

is it something that the young people talk about?

**Ms Wenzel:** I've heard situations where people do talk about smuggling products. I've also heard that what most people tend to do, especially the young persons, is they can go into a store and purchase cigarettes anyway, so why do they have to go to the black market for that. I think recently the RCMP did bust a tobacco smuggling group, so it does happen, but how prominent, we aren't sure.

**The Chair:** Thank you very much again for coming. I know you've been here through the day, and we appreciate it.

SIMON HOAD

**The Chair:** I call on the representative from the Thunder Bay District Health Unit, Geraldton branch, Mr Simon Hoad.

**Mr Simon Hoad:** I'm going to just beg the committee's indulgence and throw even more paper at you. You have a report that I've given you which is a summary of the research study. Since there were a couple of questions this morning—

**The Chair:** I'm sorry. We need to get you on the mike for Hansard—we can pass those out—just so we get all of your words enshrined in Hansard. Welcome to the committee. We thank you for the supplementary information. Please go ahead and just explain again what you've provided.

**Mr Hoad:** As I was saying, catching the interest of members in your questions as you were responding to some of the presenters, there was some concern about numbers and what some of the local trends are. Although in my submission I've given you a précis, I thought I might as well give members of the committee the original document. I've marked with a yellow tab where some of the numbers are that compare Ontario numbers with northwestern Ontario and also northeastern Ontario. Then on the page before the tab, there's a chart that makes very clear youth access.

What I'm here to talk about is that youth access to tobacco and tobacco products is a northern issue. We find ourselves in the situation, after this recent research where grade 6 and grade 7 students were interviewed, both in Thunder Bay and out in the region, that we have significant numbers of young people who have said yes, they have been smoking for three months or more in the past year.

This was a case where we weren't using a very low threshold. We didn't say, "Did you smoke one cigarette in the last year?" We said, in effect, "Are you a regular user?" For all categories we are higher than the provincial average, and the significant and shocking feature is when we look at grades 9 and 10 in the communities in the district of Thunder Bay. We're looking in the communities along the north shore of Lake Superior or along the northern route: Beardmore, Geraldton, Longlac, Nakina, that type of thing. We are looking at 40% of these 9 and 10 students who are smoking.

We can tie that in with other research that was done in Minnesota, where they went back to high school students seven to nine years after they left school. Of these

smokers who said, "Yes, I'm going to give up smoking soon." 75% are still smoking. We know that the vast majority of these smokers are unfortunately going to be confirmed in their habit and still smoking in their 20s.

On a question that one of the members asked earlier this morning around the success rate of smokers quitting, the good news is that the people who keep trying to quit eventually do quit, although it might take four or five attempts. However, there's a study in England that suggests that essentially 65% of regular smokers are never successful in totally leaving the tobacco habit. They quit for a time and they start again and they quit for a time.

In essence, they have been captured by the tobacco industry as children or as teens and they are there, that 65%, as regular smokers, to smoke till they die. There's both the good news that people do move off smoking but some really bad news in terms of the fact that significant numbers of these smokers who are starting, average age 11, in northwestern Ontario are already slaves to the tobacco industry.

That's why I feel very strongly that youth access is a northern issue, because of these larger numbers, and I think it follows from that there are some of implications when we look at Bill 119 and perhaps some directions that Bill 119 should move towards. I think what we have to do is have both a legislative approach and a proactive community approach. Clearly the schools can't do it on their own, legislation cannot do it on its own, but we all have our part to play to change the climate in which smoking behaviour happens for young people.

I think if we look at really restricting tobacco sales to minors, there are three ways that's going to make a difference. The first is, of course, that with the photo identification it's just going to be harder for them to get, but it has to have both legislation and enforcement, what the regulations are going to be. We can look at the example of Woodridge, Illinois, where they had both enforcement and education and there they were able to drop their adolescent use and experimentation by over 50%.

I would suggest that if we have the right regulations and the right clauses within Bill 119, we could look at those same types of changes with our own young people. For those young people who do become regular smokers, it's going to be harder for them to experiment, harder for them to confirm their regular smoking habit.

We also denormalize tobacco when we make very clear that it's not a legal product like all the others. I think as part of denormalizing tobacco, the emphasis in the bill to ban vending machines is excellent. This is absolutely needed.

If you look at that diagram which is the page before the yellow sticker, we asked the young people which of the four major areas where they were purchasing their cigarettes was the easiest for them. Surprise, surprise, 45% of the grade 6 students said vending machines. It's easy. It's anonymous. As long as they have the cash and they can reach high enough to put it in the slot, they can get their cigarettes. As they grow older and more confident, more sophisticated and essentially a little taller, then

they broaden out to the other outlets in the community.

The repeal of the Minors Protection Act is, again, a good piece of housekeeping, absolutely essential. Teenagers have been making creative use of this loophole for obtaining cigarettes for years.

#### 1350

I want to make some points about the enforcement of the legislation. I think it's very clear that we have to have regulations that are easy to understand and are easily usable in the community. Part of that easy use: What about a role for the citizen, for the family, when they know that their youngster, their son or daughter, is buying from the corner store? To whom can they complain? How can they make sure that practice is stopped instantly?

I think we have a tremendous change that's going to happen with the federal dropping of the taxes, that Ontario as a province is going to find the pressure due to smuggling from the east irresistible, and so we're going to have a very different climate with many more young people purchasing cigarettes and using cigarettes. We have to prepare for it by having the strongest possible Bill 119 that's going to change some of the ground rules.

I think we should broaden the role of enforcement beyond the police. You've had the presentation about a potential role for the public health inspectors. In other settings, what about municipal bylaw inspectors or security guards in malls or other types of institutional settings? These are people who have a certain role and function at present and should be given part of the duty of enforcing the act.

I want to conclude by saying parents and community groups can be powerful allies for enforcing the legislation, so give the citizens levers in the law so that we can work together to ensure a healthy community.

I want to thank both the government and the opposition for the chance to comment on the legislation and I applaud the fact that we have a cross-party resolve to try and deal with this extremely serious problem of youth being hooked into the tobacco epidemic.

**Mr Wiseman:** Your last couple of comments hit upon something that I've been a little bit enthusiastically pushing, and that is the right of parents, the enforcement. I concur with you that we need to empower people to be able to participate in the process and to know that they're not powerless in the face of huge juggernauts like the tobacco companies.

I've been sort of touting an idea of allowing parents to have civil action against people who give away cigarettes to youth or who sell them to youth so that there wouldn't just be a fining process but there would be a real fear that I as an irate parent would come down and launch a lawsuit against you for hooking my child under the age of majority on cigarette smoking.

**Mr Hoad:** I haven't thought through all the implications of a civil suit, but on first thought I think there are some possibilities there in terms of being able to give parents and ordinary citizens a role. At the moment, we have essentially wide-open sales to young people. You had Ryan, age 12, here this morning. This absolutely has



to change. As the price of cigarettes is going to go down in the midding near future, then we have to be even more prepared so that vendors know that they can only sell to someone who is 19 and has a photo ID that they're 19.

I wonder about, as part of that, the suggestions by some other people around the licensing system. If you had a licensing system of vendors, that gives you the option to say: "As a vendor you are selling a unique controlled product. You must be educated in the Tobacco Control Act and prove that you have knowledge of that before you can sell tobacco." I think there are a couple of different initiatives that we could use that will turn it back to the community and also make very clear to the vendors that this is not something that's the same as bubble gum.

**Mr Wiseman:** Your last comment here is, "Build in a feedback mechanism to the tobacco act," so that we can review it in the future. Could you maybe elaborate on that for us, please.

**Mr Hoad:** I think as legislators there are often times in which the best of possible advice and legal wording is brought together and then a year or two down the road people are quite surprised at how it actually works in the community. I think we should build in a feedback mechanism or build in a strong expectation that we're actually going to see if we're achieving the goals of the legislation, because if we're not achieving the goals, then let's have the courage and the foresight to say, "We're going to have a mechanism where we're going to back up, re-examine what we wanted to do and see if there is a slightly different way of getting there."

**Mr Wiseman:** Just as a final comment, to me the federal Liberal initiative on Quebec isn't really aimed at Quebec, it's aimed at Ontario, because the pressure now is building in eastern Ontario to force Ontario to lower its tobacco taxes. If Ontario goes, then it becomes very difficult for Manitoba to resist, and if Manitoba goes, then Saskatchewan and then Alberta. BC is at least separated by the mountains, but even then—it seems to me that the goal wasn't really to get Quebec; the goal was to buy the election in Quebec for the Liberals. But to me, the pivotal point here is in Ontario.

I just wonder if you have any thoughts on any actions or any possibilities that Ontario could use to resist this tactic, because the pressure really is starting to build.

**Mr Hoad:** I don't see that there's anything that's very easy for Ontario to do as part of the federal system. In many ways the initiative no longer lies with Ontario; the initiative, unfortunately, lies with the smugglers and the price differential. There will be almost an inevitable working out of various individuals and organized groups pursuing that price advantage.

I've had a certain perspective. When I first left university, I was employed as a detached youth worker with the Addiction Research Foundation, wandering the streets of Thunder Bay at 2 o'clock in the morning as the chemical revolution was coming north from Toronto and eventually came up to Thunder Bay about two or three years after Yorkville. I've seen on sort of a street level when you have substances that are prescribed or somehow illegal,

and of course you can still have tremendous amounts that are available for individuals with money. Unfortunately, there's a dynamic around smuggling that will be difficult to resist.

On a question or two raised by some other panel members around potentially criminalizing possession for young people under the age of 19, I myself would have some severe reservations on that. I think to a certain extent for some young people it would feed into some of the atmosphere of rebellion and independence. Twenty years ago, when marijuana and LSD were hot topics, part of a function of youth was specifically to rebel. We could end up making tobacco the forbidden fruit as opposed to just working successfully to acknowledge what a poison it is.

**Mr McGuinty:** Thank you for your presentation, Mr Hoad. I particularly liked your comments about how important it is to bring a comprehensive approach to the tobacco problem and not to underestimate the role that the community can play, parents can play, family can play, and I think not to overestimate the role too that government can play.

One of the interesting things we learned in Sudbury was that a group there had conducted a sting operation. That's the kind of idea that, if it was conducted on kind of an ad hoc basis without any announcement obviously that it was going to happen and you published the results as to who sold to somebody who was under 19 and who didn't type of thing—of course, you'd want to check with a lawyer first before you get into that on a regular basis. But that's something that I think the community can do.

On the business of fining young people, I think it's important to distinguish—I certainly wouldn't recommend that we criminalize it. It would just be a provincial offence, so there would be no criminal record associated with it, as there is right now with simple possession of marijuana, for instance.

But I think sometimes we underestimate our kids. I know sometimes we're reluctant to place any responsibility on them, but I think there comes a point—I'm not sure whether that's 12 or 13 or 17 or 18, but at some point there's a certain element, I would think it's not going too far to say, of complicity to go to the counter, pretend you're older than 19 in order to get those cigarettes which you know you're not supposed to be getting. I'm just wondering if somehow we can't bring children in as part of the team in this struggle.

**Mr Hoad:** I think there certainly is a role for children and teens as part of the team, but I'd like to see it in a slightly different context. I think when you see that 50% of the people who we interviewed had started smoking by age 11, we'd be looking at significant numbers of those smokers clearly starting before the age of majority and real questions about responsibility and knowledge of what their action is. On a superficial level they could say, "Yes, smoking is harmful," but, on the other hand, as everyone concurs, "I'm going to live for ever," and they will, until one day they discover they're 30.

1400

The way I think we can use young people and look at

that responsibility, and within our own health unit we're pursuing the idea, is to look at saying: "Young people are going to experiment. They're going to spend a period of time being hooked. Let's cycle them through faster. Yes, you're going to be smoking by grade 6 or 7; let's get you out of it by grades 10, 11 and 12 and have peer teaching and have quit-smoking programs present in every high school." Within our own work plans over the next year or two we'd like to set up some models and explore this idea.

Another part, of course, is our social marketing, both in the schools and outside. This poster passed around grew out of some focus groups this past summer and the fact that we did have a little professional baseball team in Thunder Bay. We've just done an evaluation and we're busy looking at the numbers from that evaluation, so at every step we're trying to find out what young people think directly addressed their concerns and then test, did we achieve that?

There are ways in which we want to work directly with those young people and move them out of the habit as well as prevent them starting.

**The Chair:** Thank you very much, Mr Hoad, for coming to the committee and for the additional documentation that you've provided us.

JOHN ZGRYCH

**Mr John Zgrych:** I come before you as a registered respiratory therapist. I represent myself as a concerned health professional in our community.

In society there is a growing concern about today's youth and their future, and I share a common feeling with this. Being a registered respiratory therapist raised and making my career in Thunder Bay, I'm well aware of the effects of smoking and what it has done to the community. I work for a locally owned home health care company and, as a respiratory therapist, work primarily with adults around the age of 65 who suffer mainly from lung and cardiac disease.

Before I discuss my opinions I would like to thank the committee for an opportunity to help make a positive impact on our youth and the general health of people. I would also like to thank all the responsible people in government who put so much effort to make this day possible today.

I'm here before you with full support of Bill 119. I join a large number of non-profit organizations in supporting this bill that you are well aware of. This coalition represents a vast majority of people in Ontario, and those who do oppose it are mainly the tobacco industry and those who benefit from tobacco sales. I'd like to concentrate on the issues of young people smoking and the need for licensing.

My greatest concern is the sale of tobacco products to minors. The facts remain that tobacco is addictive, hazardous to our health and that it potentially can affect our lives for ever. This is not the type of product suitable for a child, nor is a child old enough to make a responsible, educated decision. Currently minors can obtain tobacco products easily without any problem. It is estimated annual sales to children are approximately 400

million in Canada.

In northern Ontario there is a higher percentage of younger people smoking than in any other part of Ontario. The Addiction Research Foundation states that 24% of students in grades 7 to 13 smoke. Between 1991 and 1993 smoking increased significantly from 6.1% to 9.4% in students in grade 7. It has been proven that people rarely begin to smoke beyond the age of 20. The average age of minors starting to smoke is 12 to 14 years. Health and Welfare Canada states that 90% of young smokers have started before the age of 17.

Present enforcement is not enough. It's not an effective deterrent for these retailers. Licensing is the only answer to deter these statistics. Ontario needs a retail licensing system in order to better control the number of new teenaged smokers who will be addicted to the tobacco, especially in light of the new tax cutbacks that have happened recently.

In 1992 80% of Ontarians agreed that government should pass legislation restricting access of children and young adolescents to tobacco products. As well, 75% supported a ban on vending machines and agreed that tobacco should only be sold through a licensed retailer; 64% of smokers supported this action, even though it may interfere with their ability to obtain and use tobacco products.

One would think that children who are turned down early, on their first attempts, are more likely to be discouraged from smoking. In the fight against young people obtaining tobacco one can only see the importance of a vending machine ban. Sales through vending machines supply a small portion of the total tobacco market but still remain an unsupervised outlet for all young children.

It is said that 16% of all illegal tobacco sales to minors are through vending machines. This small percentage will only increase with the licensing of retailers. There is no other product that is illegal for minors available through unsupervised vending machines, so why should cigarettes be? All vending machines must be banned, especially in light of the new recent rollback of taxes.

It is reported that 20% of preventable deaths among adults can be attributed to tobacco use. I would like to see more pressure on the industry rather than the end user. I'd like to give the young people an opportunity to make their own decision at a much greater age in their life. Thank you very much.

**Mr McGuinty:** Thank you very much, sir, for your presentation. No, I don't think there's any doubt whatsoever that we have to address the issue of vending machines, because obviously we've clamped down on retailers, and then kids I think quite naturally will look elsewhere where they can make their purchases without supervision.

Whenever you pass a law you want to make sure—and it's my opinion in any event—that you're doing so in kind of a moderate way to minimize the damage that you might otherwise cause. You want to ensure that the law works towards meeting your objective.

What I'm getting at here with respect to vending



machines is, I'm wondering why we should be banning them in bars, for instance. I didn't have a chance to ask a presenter yet but I'm wondering how many grade-school kids, for instance, get their cigarettes in bars. Wouldn't you think we should be banning them in bars and, if so, why?

**Mr Zgrych:** I think, to be uniform across Ontario, a complete banning would be in order. If in fact a minor did obtain cigarettes through a vending machine in a licensed establishment, who would pay? Who's going to be to blame for this? Do you go after the owner of the establishment, the person in charge? You get into a problem of, if you're going to enforce this, there's a little bit of leeway there that you can get around it. I think that if you completely ban the act totally across Ontario, then it's uniform.

1410

**Mr McGuinty:** My colleagues the Conservatives have proposed compensating. We have people in business now who've been playing by certain rules with respect to vending machines and we're going to change the law on them. Fair enough, we're allowed to do that. Should we compensate them concerning money as a result of cigarette sales which to date have been legal? We're going to change that law. They tell us that it's impractical to convert the machines to other vending machine uses: chocolate bars, chips, these kinds of things.

**Mr Zgrych:** Personally, I think they shouldn't be compensated. I don't know what the figures are but I don't feel that makes or breaks their business. If it's in a licensed facility, alcohol would be their main money maker. I don't think I would go to a bar or friends of mine would go to a bar just because there's a cigarette vending machine in it.

**Mr McGuinty:** I'm talking about the people who make the machines and place them in different locations. I'm not talking about the bar owners as such.

**Mr Zgrych:** I'm not too sure what can happen on that.

**Mr Martin:** I want to thank you as well for coming before the committee. There has been some reference, today particularly, to the incidence of smoking, particularly among young people but other groups as well—women were mentioned—being greater in northern Ontario. Do you have any idea why that is? Is there anything that we should be doing differently re this legislation that could address that, for me, quite alarming revelation?

**Mr Zgrych:** I feel that in Thunder Bay and northern Ontario in general there are a lot of working-class people. Personally, I've worked in paper mills and that type of business and everybody smokes. If everybody sees everybody smoking, it rubs off on the next person, to the kids and to other family members. I'm not exactly sure why northern Ontario does have a high population of smokers but it is definitely there.

**Mr Martin:** If we follow that, then some review or moving more quickly to looking at and maybe doing something about it, the smoking-in-the-workplace piece of this whole package might be something that would

address that particular issue.

**Mr Zgrych:** I think Thunder Bay would be a vital source of doing information studies on because it's such a unique area that you can only learn from it.

**The Chair:** Thanks very much for coming before the committee this afternoon. We appreciate it.

SUSAN LOEWEN

**Ms Susan Loewen:** My name is Susan Loewen. I am a pharmacist practising here in Thunder Bay. I have been a pharmacist in Ontario since April 1993, just last year. I have come to speak to you today to show my support for Bill 119, the Tobacco Control Act. I also speak on behalf of Janzen's Pharmacy, which is a tobacco-free pharmacy in Thunder Bay and has been since 1989. I do support all of Bill 119, but being a pharmacist I would like to show my support for the removal of all tobacco products from all pharmacies.

I consider myself a member of the health care team. As such, my job is to promote a healthy lifestyle and prevent disease. My job obviously also includes ensuring the safe and effective use of medicine, but that's not where it stops. This may seem naïve, but I don't understand how tobacco and pharmacies were ever mixed in the first place. It just doesn't seem to make sense.

I guess at one time tobacco was just another product that everyone sold, just like tissue or gum or a newspaper, but now for years we've known how dangerous this is and that it is the leading cause of preventable illness and death, so I don't understand why we still sell it. Just because we always have doesn't make it right and it doesn't mean we still should sell it.

To fix this, voluntary withdrawal was introduced, for pharmacists to remove it themselves from their shelves, and many pharmacists in Ontario have. In Thunder Bay there are three independent pharmacies that have a full front store, and two of those stores have removed it. There's only one that does have tobacco. There are also six other smaller clinic pharmacies in town that may not have a full front store, but they do not sell tobacco either.

Unfortunately, voluntary withdrawal didn't work 100%. I have an opinion as to why it didn't work 100%, and that is because if you are a pharmacist working in a national chain or a small local chain, you don't have the power to remove this product from your shelves even if you want to. I would say that if we did have the power to remove it ourselves, more would have.

When you really think about it, voluntary withdrawal for these large chains can't work because there is a tremendous amount of money at stake: 23% of all tobacco in Canada is bought in drugstores and, of that, one third is from Shoppers Drug Mart. So 8% of all the tobacco sold in Canada is from Shoppers Drug Mart. I don't know how much money that is, but I'm sure it's a lot and they're not going to give that up voluntarily as a business. It's purely a money matter.

I don't think we can make this a money issue because this is a public health issue and we have to show the public that we are health professionals and we won't sell a product that kills them. We have to set a role model. We have to be a positive influence, especially for the

children, because otherwise it's a very mixed message when we say how bad tobacco is and yet we still sell it.

I would like to applaud the government for even proposing Bill 119 and to thank everyone who is showing support for pharmacists to help us remove this from our stores when we can't do it for ourselves.

**Mrs Haslam:** I'm interested in your figures, that 23% of tobacco sales are in pharmacies, a third in Shoppers Drug Mart. That's approximately 8%. Where did those figures come from?

**Ms Loewen:** I have a pamphlet with those figures in it.

**Mrs Haslam:** Do you know the name of the pamphlet?

**Ms Loewen:** I don't know the name. I have it with me, though. I can get it for you.

**Mrs Haslam:** I'd like to take a look at it in a couple of minutes. I have one quick question. You said there's one out of three independent pharmacies here in Thunder Bay that sells tobacco products. Is it located near this facility?

**Ms Loewen:** Near this facility right here?

**Mrs Haslam:** Yes.

**Ms Loewen:** It's in Westport, which is close to the mountain.

**Mrs Haslam:** The reason I'm asking is that I happened to go across to the mall and there was a drugstore there which wasn't a chain, it was more like an independent, and they sold tobacco on the edge there. It was just really very interesting because I could see all these signs that said you must be 18 to buy a lottery ticket. There were three signs that said, "No lottery tickets will be sold to anybody under the age of 18."

It took me the longest time to find the one sign in the corner on the right-hand side that said, "You must be 18 to buy cigarettes," but all of these signs were hanging on the cigarette counter that said, "You must be 18 to buy a lottery ticket." I found that very interesting. I wondered if it was that particular store that sold the tobacco or not. Those are my clarification questions for now. Thank you.

1420

**Mr Carr:** Thank you very much for your presentation. I was anxious to know what you think will happen. I think you mentioned the 23% right now. What do you think will happen when this bill goes through? Are we going to see a shift to other places or are we going to see a decrease? What do you think is going to happen?

**Ms Loewen:** You'll see a shift because it will have to go somewhere else. You'll probably see a decrease. I don't know if it will be right away, but I think if the message goes out that pharmacists won't sell this product any more, some people are going to have to think twice about it. Maybe not the people who are established smokers, but children might think about it more if we don't sell it to them, that maybe there is something really wrong with this.

**Mr Carr:** Who do you see jumping in? Who's going to replace it, do you think?

**Ms Loewen:** Probably corner stores. That's what I

would say. If it's not in a pharmacy, it's not as easily accessible, probably the corner stores.

**Mr Carr:** Okay, thank you. Good luck.

**The Chair:** Thank you for coming before the committee this afternoon and sharing your experience with us.

ONTARIO LUNG ASSOCIATION,  
THUNDER BAY REGION

**Ms Kathryn Kaipio:** I'm Kathryn Kaipio and I'm the executive director of the Ontario Lung Association, Thunder Bay region. My colleague is not here. He is the owner of one of three smoke-free bed-and-breakfast restaurants in Thunder Bay. He's also a member of the Non-Smokers' Rights Association. He's coming today, or he's trying to get here. He's out in rural Thunder Bay and there must have been a problem with roads or something, construction. He's coming here to speak to you on behalf of his children, so he just may make it. I hope he does before we're finished.

**The Chair:** We'll try to make sure we can get him up to the table when he comes in. But we welcome you, none the less, to the committee and we do have a copy of your written submission, so please go ahead.

**Ms Kaipio:** It's important that interest is given to my introduction in my written submission because it's important that you know who I represent. We're an organization that covers all of Ontario. However, here in Thunder Bay, this particular associate is solely funded by the contributions that come in from residents in the city. We don't receive government funds in this associate and we try very hard not to. We try to be as independent from government as possible when it comes to what we do in the community.

We have a very large geographic area, from Atikokan in the west to Marathon and Manitowadge in the east, and yes, we do have a higher incidence of smoking in this area, along with a higher incidence of suicide and alcoholism and other socioeconomic problems which seem to be greater here in the north.

In 24 years, this associate in Thunder Bay has been working very hard at reducing the incidence of smoking in the north with smoking-prevention programs, working at a smoke-free spaces bylaw for the city and smoking cessation programs. We have a very, very excellent tool that is called the Lungs for Life school program and we have been teaching that in the schools for the last nine years. That's to teach children from kindergarten to grade 12 all about smoking, prevention of smoking and cessation of smoking.

I recently measured with a carbon monoxide analyser the lungs of a 12-year-old boy who was very small for his age—he looked more like nine—and his carbon monoxide reading was 80 parts per million. If a factory has a carbon monoxide reading in the ambient air of 40 parts per million, it's closed down by the occupational health and safety people. This boy had twice that amount in his lungs. This boy represents thousands of youngsters in the north who have ready access to tobacco.

We've been working hard on this problem. We've made it known to our donors, and so today I'm speaking for our donors, for the members, for the board of direc-



tors and the staff who make it a vocation rather than a career to work at this. I also speak on behalf of a group of 64 people who have severe lung disease. They call themselves the Short of Breath group. I would say 95% to 97% of them have emphysema and/or lung cancer and/or asthma due to smoking.

I counsel them in the warmer months. Because of their severe lung disease they can't come out in our cold winters. They get counselled on education and rehabilitation for their lung diseases from approximately March through October of every year. I see the ravages three quarters of the year, twice a month, with these people. I've been shocked at how limited many of their lives are simply because they can't breathe, and when you can't breathe, nothing else matters.

What we're trying to achieve here is to make sure that 40 years from now, our young people such as Ryan Fitzpatrick, who spoke to you today—who, as you know, was able to access and purchase many packages of cigarettes—aren't the people in the Short of Breath club when they're 40, 50, 60 and 70 years old. We're looking at a very long-range program for these young people.

I would really like to congratulate and thank this committee, the government and the members of the opposition party for working together on this health issue. We support you strongly and really appreciate the amount of work you've put in so far. I know that these hearings are tedious and I've been watching them from the beginning. I just want you to know that you're very much appreciated for this interest.

We strongly support the provisions laid out in Bill 119. We want controls tightened on sales to minors. We support the reduction of tobacco outlets, namely, vending machines that are used by over a third of young people. We want to see the cigarette ban enforced in pharmacies and we want to see the way paved for the elimination of tobacco. We want to see ads and sponsorships cancelled. We want to see smoking prohibited in designated places, including schools, and we want to strengthen non-compliance penalties.

We support all that Bill 119 outlines, but in addition to what Bill 119 states, I have four areas that I would strongly recommend you look at.

The lung association wants to amend the bill to require a retailer licensing system in order to better control the number of new teenage smokers who will be added to the tobacco market because of the tax reductions. My submission was done, in my mind at least, a couple of weeks ago. Then when we had the recent tax reduction I had to completely change my stance because I think you have to take another look at Bill 119 in light of this tax rollback. I don't think it's strong enough as it is. To amend the bill to include licensing is an absolute must.

We want you to immediately require plain packaging to decrease the attractiveness of cigarettes to young people, break the link with tobacco company sponsorship and advertising and help control smuggling by distinguishing the domestic package from the package destined for export. The federal government intends to study plain packaging. We want action now. Bill 119 already allows for it, and we want it specifically required by the bill.

Require that smoking be banned in all public places except where specifically exempted by regulation. This will be important because tax reductions lead to more smokers, which will in turn lead to more smoking in public places and more involuntary exposure of non-smokers to secondhand smoke.

#### 1430

Immediately move to amend the Smoking in the Workplace Act in order to ban smoking in all workplaces in the province at the earliest possible convenience. I know you have to examine this bill, but I hope you will place that in order of priority at the top, because we have a very, very weak workplace act at the moment.

The lung association receives calls almost daily from employees who feel victimized by smoking that goes on in the workplace, and also really let down by the fact that there's such a weak workplace act that exists. So please do look at smoking in the workplace and strengthen that act.

Enforcement is the key, I think. When you look back at licensing, if you have retailers licensed, we must have enforcement. Without sufficient human and financial resources and the political will to use them in support of the provisions of the act, the legislation will be ineffective. To date, the provincial government has not indicated how it plans to enforce the act.

The lung association believes the government and the opposition parties want to ensure that the legislation is consistently applied, effectively enforced and is easily interpreted by all parties affected by the legislation. We recommend that at the earliest opportunity the government make public the details of its plans with respect to enforcement of the act.

I'd like to conclude by saying that as a member of the Ontario Campaign for Action on Tobacco, we strongly support everything that is said in the OCAT submission. We worked very hard to bring all this about, and as the lung association's submission does not encompass all that the OCAT submission does, please know that we support that wholeheartedly.

Bill 119, with the above amendments, is a prescription plan to give kids a chance, and I want to reiterate the fact that this is for children, not for smoking adults. It's for the protection of children who haven't started to smoke yet. Children are making the decision to smoke between the ages of 12 to 15 years old, and they're being seduced by advertising, by peer pressure, by image packaging, by examples set by parents, by the pharmacists. They're also being seduced by the fact that tobacco is accessible.

Of children between the ages of 12 and 15 years old who decide to smoke, 94% are going to continue smoking until adulthood. I want you to think about this just as I close. When a child between the ages of 12 and 15 years old makes the decision to start smoking, that is the only lifetime decision a person is going to make at 12 to 15 years old.

We don't make career decisions. We don't make hard decisions about which religious belief we're going to have. We don't make decisions about the mate we choose for the rest of our lives. We don't make decisions about

almost all important things. But we're asking children between the ages of 12 and 15 years old to make decisions, when they're under the pressure of the tobacco industry and the poor example set by pharmacies and adults, and by government, to make a decision about the health they will enjoy, or not enjoy, for the rest of their lives.

On behalf of the lung association, Thunder Bay region, I urge you to remember through your work with this act that this is for children and for the protection of their health for a lifetime.

**The Chair:** Thank you, and we now welcome you, Mr Nobel, to the hearings. Would you perhaps like to add something from your own experience?

**Mr David Nobel:** Yes. First of all, I'd like to apologize for being late. I live 30 miles out of town and I tried to print all the briefs up. I had problems with my laser printer. I wasn't sure whether I should get the copies made or come in and try to get them made here. I did it this way and I'm very sorry that I did not arrive on time.

**The Chair:** That's all right.

**Mr Nobel:** I have a special interest in Bill 119 because I have two daughters, one a teenager and one a pre-teen. I'm very concerned about whether or not they are going to be tempted into starting to smoke. I believe the whole thrust of Bill 119 is towards preventing young people from starting to smoke. It's not directed against those who are already established smokers; it is designed to prevent new smokers from entering the marketplace. Therefore it is a vital bill, from my own personal interest and I'm sure the interest of many parents across Ontario.

I feel that what we have right now in Bill 119 is excellent legislation. It's something which will put Ontario in the forefront in North America and the whole world in terms of prevention of smoking and anti-smoking, anti-tobacco.

What we are missing in Bill 119 now, I think, most importantly, are two vital items. We do not have in place anything which addresses the issue of licensing and plain packaging, and there should be no mistake made. If you're really serious about combating among teenagers, it has to be approached as a total battle plan.

If you take two or three items, we have some good initiatives in here now. We have age of majority now. We have vending machines being banned. We have the termination of sale of tobacco in pharmacies. These are important strategies, but they have to work synergistically in order to be really effective. Otherwise, we'll see some benefit, but we'll see minimal benefit.

I think the two most important things lacking here are the licensing of retailers and plain packaging. This is based on extensive research which has been done in this field prior to today, over many years, according to studies done in the States, where in selected areas they have introduced really tough laws about regulating retailing of cigarettes. In other words, there's licensing and there are really stiff penalties put in place if you sell cigarettes to minors, which you're not supposed to do now but which is not enforced. It's just widely disregarded.

Where that is done, we see a dramatic drop in teenage smoking, up to 70%. It will not happen only through education, it will not happen only through banning vending machines, it will probably not happen to the degree we would like to see and to a significant degree with anything which is in Bill 119 now. It will have an effect. It will not have the dramatic effect that would have. That simply puts real teeth into what is the expressed desire of the legislation, and without it the legislation will not have the effect we would like to see.

The second issue is plain packaging. This is another vital issue. It's the issue I think you'll see the tobacco industry fight the most strongly on, with the most really dishonest types of arguments.

The bottom line on packaging is that the cigarette industry knows the packaging sells the cigarettes, and specially among teenagers. Studies that have been done here in Canada recently have shown that packaging has an enormous influence on teenagers who are thinking about smoking, because they're so impressionable and because image is so important. There's no brainwork involved here at all. It's all response to image.

When you take away the attraction of packaging—and the packaging attraction is amped many times by tying in with corporate sponsorship, with the logos, with the symbols and the advertising effect of having that package coming out of pockets, thousands, millions of times a year across the country—you remove a lot of the incentive of young people to get involved in smoking. It sounds simplistic, but it is nevertheless a fact.

Probably the key element, even more than licensing, to reducing teenage smoking, to preventing kids from smoking who would otherwise be attracted to cigarettes is to take away the attractive packaging. If you don't address that, in conjunction with the licensing, we're really taking a great deal of the wind out of the sails of this bill, and I urge you to include this in Bill 119. It is vitally important.

We also know that a majority of people in Ontario support this kind of legislation. There was an Environics poll that was done a number of years ago, two or three years ago, which showed rather conclusively that smokers and non-smokers together support the restriction of sale of cigarettes and tobacco products to minors, to teenagers. There is broad-based support.

1440

I urge you to look at where the opposition to this bill comes from. We have an organization called the Committee of Independent Pharmacists. Where do they get their money? I think a lot of you are already aware of this. Where are their supporting financial statements? What kind of organization is it? Likewise the Smokers' Freedom Society: What is their membership? Has anybody here seen a list of their members? Have you seen a copy of the minutes of their meetings? Have you looked at their financial reports?

They have not been forthcoming on this, contrary to the practices of almost every group that is appearing before you to lobby for this bill. Most of the major health and social advocacy groups have open books, they have



open membership; you know what they represent and you know who's funding them.

I put it to you that the tobacco industry is behind most of the most vocal and high-profile opposition to this bill. I put it to you that there is not significant opposition to this bill among ordinary Ontarians, which is not to say there are not independent retailers and vending machine operators who will suffer under these proposed measures.

But I feel and I think, if you look at this squarely, this is a necessary evil, that is, you cannot have social change this dramatic, social change which is trying to reflect an evolving consciousness about health and smoking, something which has been evolving since 1964 and the US Surgeon General report and much, much faster and at a much, much faster rate—and we know how bad it is and how addictive it is now—you cannot effect that kind of social change without somebody having to give somewhere.

We have an established, very, very profitable industry, and somewhere along the line the rights of merchants and the industry have to be balanced against the social responsibility of the government and the people of Ontario and their rights as well, the rights of ordinary citizens. This is not easy to do, but it has to be done, and I think even a lot of people who have a vested interest in this recognize this and are willing to make a lot of concessions to see it happen.

I hope my daughters never start smoking, but that is their choice. I can't prevent them if they want to, but I hope the legislation you're going to be putting in place, Bill 119, will be effective enough and strong enough that it will help them to choose not to smoke.

**Mrs Haslam:** I'm going to be very quick. On the last page of your submissions, there was something there and I wanted to clarification of it. I'm doing this in a very non-partisan way, but as a teacher-librarian, I like to know where things come from and where they were quoted from and where I can follow up on it.

You start on page 5 indicating your anger at "the Prime Minister's devastating decision to roll back tobacco taxes, which will lead to thousands more tobacco-related addicts, disease and death." Then on page 6—do you have this? This is the lung association, Thunder Bay region—you commend Mr Rae, Mrs Grier and also Ms McLeod for her commitment and courage in light of the current pressure and controversy around the taxes.

Did she say something locally around this issue? I hadn't heard anything in the Toronto papers, and that's why I wanted to know if she has come out and I've missed it because it has been in the Thunder Bay papers that she wants us to stand firm on the tax issue. Could you clarify that for me?

**Ms Kaipio:** Yes, I'd be happy to do that. I haven't seen the paper or a television for the last couple of days. I've been raising money at a casino here for the lung association. So I can't say that she didn't. However, she called me in my office on Friday to tell me personally that she also is outraged with the rollback and that, yes, she supported the government of Ontario in trying to hold out. We understand how difficult it is, but she wants us

to know that as of Friday, she supported it.

**Mrs Haslam:** That does help clarify where that information came from. Thank you.

**Ms Kaipio:** You're welcome.

**Mr Martin:** I noticed that you made reference in here again about how in the north we have a seemingly greater percentage of our children and women smoking when you compare it to the provincial average.

I have four children as well, living in Sault Ste Marie, and my image of the north is free and lots of fresh air and all that kind of thing. I guess it's just disturbing for me today to be hearing these kinds of things, because I assumed differently.

Again, you'd mentioned the workplace legislation and doing something about that. The previous speaker had said that probably was one of the main causes of these percentages being higher. Do you have anything else to say on that?

**Ms Kaipio:** I'm sorry I missed the first part of your question, but I assume what you're referring to is the north and the higher incidence of smoking here.

As far as youth is concerned, I think there's a problem the north has had for many, many years. I think it has always been here. We seem to lag behind social trends that are set in the rest of the province by at least two years. Where smoking education started to be popular, this part of Ontario didn't see it for two to five years. We're way behind the rest of the province.

I think that's one reason why there's a higher incidence; also because we're in very isolated communities here—the long cold winters and so on. A lot of children aren't involved in sports. They come from lower-income families. They will, as they call it, "hang out in malls," and smoke and that's what they call their recreation.

As far as the workplace act goes, I think people are smoking more because they aren't kept from smoking at work and you're just going to see more of it. There's more environmental tobacco smoke because of it and the parents of these children are continuing to smoke. It's harder for them to quit.

If you had 100% ban on smoking in the workplace, you'd have people for seven to eight hours a day, with the exception of their lunch-hour perhaps, not smoking at all. You'd have a significant reduction of smoking among the parents of these children as well.

**The Chair:** Thank you both for coming before the committee. Mr Nobel, thank you for getting here and for the copies of your submission. We appreciate both of you being here today.

1450

#### THUNDER BAY MEDICAL SOCIETY

**The Chair:** If I could then call the representative from the Thunder Bay Medical Society, Dr Belda. We have you down here as representing the Thunder Bay Medical Society, but I notice that the presentation you've submitted to us refers to the Ontario Campaign for Action on Tobacco Smoking.

**Dr Antonio Belda:** Yes, actually, my secretary has put the title. It should be a presentation from the Thunder

Bay Medical Society.

**The Chair:** This is a presentation on behalf of the Thunder Bay Medical Society.

**Dr Belda:** That's correct.

**The Chair:** Thank you. Welcome to the committee and please go ahead.

**Dr Belda:** First of all, I want to thank you very much for coming 1,500 kilometres up north, the same distance from Toronto to Disneyland, but I think you may have some fun here too.

As a paediatrician and allergist, every day I witness the effect smoking has on children and their families. I am going to review the information that I have here and add some additional information that I hope will help you to make decisions when you are dealing with the law itself.

The frustration that we have is that most of the children, especially in northwestern Ontario, can easily get access to cigarette smoking. Actually, one of my patients, a 16-year-old girl who started smoking at the age of 9—I was amazed to hear her story, that it was very easy for her to start selling newspapers and get enough money to go to any corner store, saying that the cigarettes were for her parents, and they were sold with no question whatsoever.

Unfortunately, this was a cool thing for her to do at that time but now she's 16, she has bad asthma and she's badly addicted to the nicotine. We're dealing with a very bright and alert girl, very intelligent girl. She wanted to quit. She couldn't do sports that the other friends were doing and she couldn't quit. She was physically and psychologically addicted to the nicotine. It was really sad to see because she wanted to quit and she was asking for help.

We're not talking about somebody who doesn't know what she's doing. We have to consider that this is a powerful addiction. If we had the same kind of patient with a cocaine addiction, I'm sure you would look for different ways and you would consider a different problem, a different higher level. But unfortunately nowadays in our society we believe and we tolerate smoking because it's a legal product.

Unfortunately, if you look at the history of smoking, this legal product kills eight times more than car accidents, suicide, murder, AIDS, drug abuse, all of them combined. I'm sure you likely have seen this bar picture. This is the estimated annual number of preventable deaths in Ontario only, and this is the amount of deaths that can be prevented in Ontario, comparing with the alcohol, traffic accidents and all these things. The illicit drugs only kill 100. Cigarette smoking kills 13,500, but it's socially acceptable. These are factual data.

The other problem we have is that, unfortunately, our governments in a conscious way tolerate, support and advocate cigarette smoking because of the governments becoming very dependent on the taxes collected for the cigarette smoking. Unfortunately, because it's not going to influence the people immediately but in the long-term kind of investment, this is something that's put up and they say, "Well, that's a problem that's going to be dealt with by future generations."

If you will look at the ads in the 1940s—and you have some photocopies there—"More Doctors Smoke Camels Than Any Other Cigarette." This was socially acceptable in the 1940s. You see Ronald Reagan with one of his first lies, saying, "I Wish My Friends Merry Christmas with Chesterfield," and it was socially acceptable. Unfortunately, that's when the glamorous pressure on women that smoking was the thing to do started. It's sad to see that unfortunately cigarette smoking doesn't produce the effects immediately; it takes 20 years, 30 years, 40 years to start showing the effects.

If you can look at this loose sheet that you have about the incidence of cancer in women, this will really remove your tranquillity when you go to bed, thinking of the increase in the incidence of lung cancer in women since 1970. Thirty years after Ronald Reagan was telling you to smoke Chesterfield, finally you start seeing an enormous speed of the incidence of lung cancer and you can see it's almost touching the breast cancer that hasn't moved in incidence. But look at the speed of lung cancer going up.

Let me just tell you the end of this story. Last year, for the first time in world history, more women were dying from lung cancer than breast cancer. You have a strong moral responsibility to leave a legacy for future generations. You have to act now. This has to be beyond any kind of a political interest. As a human being, you have this moral obligation to do that.

It is really sad, the power of the advertisement. Those cigarette companies have been selling an image of deceit, targeting especially the young generation before what we call—and you have heard many times—the age of responsibility. We have to understand the age of responsibility actually comes after you already are addicted to cigarette smoking.

If you look at the advertisement of the young woman: "I always take the driver's seat. That way I'm never taken for a ride." Give the women independence; give the young generation, "If you always follow the straight and narrow, you'll never know what's around the corner." Be daring. If you find cancer around the corner, that's your problem. We've already got your money.

If you allow me to advertise this brand of cigarette, which I call Kancerette, which gives you power, freedom, excitement, pleasure, control, security, confidence, stability, experience, life; if I advertise these, I'm sure I'll go to jail for misleading advertisement. But we are not doing this. We are accepting the misleading advertisement of the tobacco companies. Legally, we allow them to lie to the young generation because we need their money and the taxes generated by cigarette smoking.

I think Ontario should remain the leader, blocking access to tobacco. We have to keep the prices of tobacco high. We have to license the retailers. We have to ban all the vending machines and we have to raise the age of purchase. If you could actually go a little further and try to get right now all the cigarettes in a plain package, I think we can identify who's smuggling cigarettes from Quebec, which is now going to be the new thing to do, and we can obviously pick up who is smuggling or close the border.



You should really do this so you can destroy all the image that the tobacco company has been building in the last 40 or 50 years. Please give the children a chance and act strongly now against cigarette smoking. Thank you.

**The Chair:** Thanks very much and thank you for the old ads as well. We've heard about those but I don't think we've seen them quite as graphically as you've brought them to us today. We'll begin questioning with Ms Carter.

**Ms Carter:** Thank you for your forceful presentation and, as the Chairman said, the ads, which certainly tell their own story. You state on page 3 that governments become dependent on the taxes collected from cigarette smoking. I guess in the old days when we didn't fund health care like we do now, and when also there weren't as many high-tech procedures which cost a lot of money, maybe that was true. But I think we heard earlier today that actually the cost of treating people with cigarette-induced disease now equals the amount that governments take in in taxes, or more.

**Dr Belda:** Actually, I think it costs much more than from the taxes we collect.

**Ms Carter:** In other words, if we could reduce smoking and lose the revenue for that reason, then governments would not be out of pocket.

**Dr Belda:** That's correct. I think that's a correct assumption. I have read some estimates, because estimates are the only thing we have, that the future cost to the health care is going to be more than the money that you collect.

Unfortunately, you may have a blind government which decides, "That is going to be for the next government to come, so I'm not really worried about it." I'm appalled and worried about the federal government making a decision to make it easier to smoke because it's going to solve a political problem that we are all aware of, but not seeing the consequence of social costs in future years.

1500

**Ms Carter:** Of course, that's a lose-lose situation, because governments are going to be collecting less in revenue, but there's going to be more smoking because it's cheaper.

**Dr Belda:** And it's going to cost more money.

**Ms Carter:** Presumably the health costs are going to go up just as the revenue goes down. What would you do if you were the Ontario government in the face of the new situation created by the federal decision and the threat of cheap cigarettes coming in from Quebec?

**Dr Belda:** First of all, I think you must do the plain cigarette package to easily identify who's smuggling cigarettes. Second, you keep increasing the prices to make it less accessible.

**Ms Carter:** Can we do that in the circumstances?

**Dr Belda:** Third, you have to enforce the law. What you have seen in the last two weeks is a weak enforcement of the law, which is the beginning of the destruction of our whole society. You cannot allow this to happen under any circumstances.

I lived under a totalitarian government for 15 years in South America, and I know you can lose control of society if you don't abide by the law. You have to enforce it. You cannot let interest groups direct what the elected government's going to do. You have to enforce it, even if it means that there are going to be some people die. We have 13,000 dying from cigarette smoking.

**Ms Carter:** Another Oka?

**Dr Belda:** You don't want to have another Oka? That's totally irrelevant. If we have to have another one, let's have it.

**Ms Carter:** But in view of the legal reduction in prices in Quebec, what can Ontario do to stop those cigarettes coming here? How would we enforce that?

**Dr Belda:** Install severe fines and penalties for anybody who even smuggles through the province.

**Mr Eddy:** Thank you for your presentation. We appreciate your comments. I agree with you about the weak enforcement. There's been extremely weak enforcement in regard to smuggled or contraband cigarettes. Very, very weak. Secondly, there's been absolutely no enforcement, we've heard, on selling cigarettes to minors. It's non-existent, the enforcement, we hear.

You've talked about licensing. You probably know, of course, that in the act there are going to be what could be considered heavy fines for selling cigarettes, tobacco products, to people under the age of 19. Do you see that licensing should also be put in place along with that, or do you feel that very heavy fines will serve the purpose without the licensing?

The reason I'm asking that is, if you license so many outlets, like your corner stores, confectioneries, you're still going to have tremendous availability. So what do you think about fines versus licensing?

**Dr Belda:** The thing is, you have to have an enforcement mechanism.

**Mr Eddy:** Yes, sir.

**Dr Belda:** The problem is, if you put only fines without licensing, they may be willing to pay the fine and may even be actually sponsored by the tobacco companies: "I will pay your fines." But they will not have any incentive not to sell unless the licence is cancelled for ever. Now they will think twice before doing it. I'm sure the tobacco companies may be willing to subsidize the fees, because it's peanuts for them. I think they must go together, licence and fines.

**Mr O'Connor:** The bill itself has a statutory prohibition which would forbid people from selling if they are in contravention, which would be, I assume, what you're talking about in the licensing. Would you suggest that the prohibition remain in the bill?

**Dr Belda:** If they remove—

**Mr O'Connor:** If you are caught as a retailer selling cigarettes to a minor, then you'd be prohibited from selling cigarettes.

**Dr Belda:** That's correct.

**Mr O'Connor:** Is that acceptable?

**Dr Belda:** If I lose the licence, I cannot sell it.

**Mr O'Connor:** You don't even need to have a licence. What I'm saying is, in the legislation right now, if you are a retailer selling and you are caught selling to a minor, then there is a prohibition that won't allow you to sell it again. There are also successive fines, as well as putting signage in your retail establishment saying that you have been found in contravention of the law by selling tobacco products to a minor.

What do you think would have more impact? A licence on the wall that is gone, or a sign on the wall saying, "This person sold cigarettes to minors in contravention of the legislation," and then had to put it on the wall.

**Dr Belda:** If it works, I think that's good enough. But people like symbols and a licence is a symbol. If you remove that symbol, they may be psychologically affected more effectively.

**Mr O'Connor:** Interesting. Thank you.

**The Chair:** Thank you very much again for coming before the committee.

MARCIA MABLESON

**Ms Marcia Mableson:** My name's Marcia Mableson and I'm a public health nurse with Thunder Bay District Health Unit. I work in the Nipigon branch. I was born and raised in Nipigon, small-town northern Ontario. I've been a public health nurse since 1981.

I'd like to thank the social development committee for giving the people of northwestern Ontario the opportunity to present their view on this bill.

What I'd like to do is just take you with me to small-town northern Ontario. I'd like to give you some insight into the extent of the tobacco problem in our small northern Ontario towns. To provide you with a balanced view, I have compiled anecdotes from public health nurses in five northern Ontario communities. I will be relaying them as my own experiences, but they are all true region-wide.

We begin with my return from Christmas holidays in London, Ontario. Not only are the potholes and narrow highway a challenge, it's impossible to find a restaurant with a no-smoking section. Everywhere I stop, grey, billowing cigarette smoke fills the air. My seven-year-old son, who has asthma, looks up at me and says, "I guess we eat in the car, right?"

Upon my return home the next day, I head off to work. On the way I stop at a local convenience store for a cup of coffee. Everyone has congregated at a stand-up coffee counter. The store is filled with smoke. As I join the queue at the till, I notice a couple of grade 8 girls walking out the door, unwrapping a pack of cigarettes as they head down the street to school. My son tells me these girls smoke across the street from the school during lunch break.

I head off to my office, which is located in the community hospital. As I approach the front door, I am greeted by a patient and his family who have seated themselves outside, next to an overflowing ash can. It doesn't matter how cold it is; they really need a smoke.

Later that same day I visit a senior kindergarten class to present a lesson on tobacco use prevention. The children are surprised to learn that secondhand smoke is

dangerous. Half of them live with at least one parent who smokes. They ask me what to tell their parents about smoking. At recess I walk down to the staff room to join the teachers on their break. I go to the non-smoking staff room, but several teachers congregate in the designated smoking room just off the gymnasium. The smoking teachers are in full view of the students who spend their break in the gym.

Before lunch, I head off to the local day care and find the staff enjoying a morning break. They happily drink their coffees and smoke their cigarettes in a room open to the view of the preschoolers who play in the next room. These day care attendants are their role models.

I look forward to lunch that day; I'm meeting a friend I haven't seen in a long time. We arrange to meet at a local cafe. Everyone is hungry. The place is packed. There isn't a non-smoking section. We try to find a table in a corner away from the smoke, but there's no escape. The waitress lights a candle and says apologetically, "Maybe this will help." After lunch I join the slow-moving line at the till. Someone remarks that it's a good thing they have cigarettes in the vending machine right by the door. It's the fastest-moving line in the place.

#### 1510

In the afternoon I visit one of the many teenage mothers in the community. She's 17 and on welfare. Her premature baby is two weeks old. They live in a dark basement apartment which is poorly ventilated. She's trying to be hospitable, but I can see she's nervous. She lights up a cigarette and then jumps up to attend to her coughing baby who sleeps nearby in a swing. She opens the window a crack and says: "The doctor thinks the baby might have asthma. It runs in the family."

I finish off my afternoon with a phone call to a 60-year-old ex-smoker who needs help to pay her medical bills. She has diabetes and emphysema. She tells me she needs all the financial help she can get because her oxygen and medications cost her well over \$300 a month. She expresses concern about her 40-year-old daughter who is a heavy smoker.

Next, I pick up my seven-year-old son from school. As I wait in the car, I notice the school principal huddling in the corner, stamping his feet to keep warm and having a cigarette.

On the way home I stop at the drugstore for a few items. As I walk through the door, I immediately catch a whiff of the cigarette smoke drifting from the back of the store. I catch a glimpse of an all-too-familiar and ironic sight: the local pharmacist puffing away behind the dispensary counter. This is life in a northern town.

That evening I return to work to teach prenatal classes. I am presenting a lifestyle class for first-trimester moms and dads. The class is well attended, approximately 12 couples. Their ages vary from 16 to 35. We talk about the effects of cigarette smoking on the unborn. The group is divided on the issue. A quick show of hands reveals that about one third don't smoke. One third say they've quit for the pregnancy but can't guarantee abstinence after the baby is born. The rest say they've tried and can't quit.



They say there's no way they could quit because their partner won't quit or they'd be too stressed out if they did. They say the stress of trying to quit would be harmful to the pregnancy, and in this town there are no support programs to help them break the habit.

When I finally get home to rest for the evening, I am shocked when I open the weekly paper. Right there in the middle of the page is an ad from a local arcade advertising the sale price on cigarettes. They boast about selling all brands, and I believe that ad is in your attachment.

I look forward to the weekend because my son will be playing in a Tom Thumb hockey tournament in a nearby town. The temperature is 40 degrees below and the rink isn't heated. After a half hour, I have to go into the lobby to thaw out but I don't know what's worse, the cold or the smoke. The snack bar and tables are filled by patrons. I figure at least half of those people are smoking. The rest of the lobby is filled with parents and spectators and it seems like half of them are smoking too.

I bump into a 14-year-old boy from the region who is smoking. I'm bold enough to ask him where he got the cigarettes. He tells me his parents gave them to him. He and his parents smoke together, he adds. He says it's their way of bonding.

That night my husband and I contemplate taking in a movie, but there's only one theatre and smoking is still allowed in the balcony. In this community, even going to a movie can put your health at risk.

I don't think I have to tell you what the problems are. By this point, you've heard it all before, and I'm equally confident that you've got a pretty good idea what to do about it. I'm not so naïve as to think we'll totally fix this situation with Bill 119. It's taken a long time to get this bad but we must make a start.

Our towns need help in controlling our sons' and daughters' access to cigarettes. We need help with implementing and enforcing strong and effective bylaws, bylaws that limit access and prohibit smoking in public places. We must protect our children from falling prey to the tobacco industry. We owe it to our children, the future of Canada.

**The Chair:** Thank you for what I must say is a unique presentation. We appreciate the way you approached that. I think it gets your message across very clearly. We'll begin the questions with Ms Haslam.

**Mrs Haslam:** I just want to say thank you also. I thought I'd heard it all before too until you came with this, as the Chairman said, very unique presentation. I really commend you on hitting us where it hurts, and that is where we live.

I don't think I've got any questions. I don't think the committee will believe I'm speechless. I've never been speechless before in my life but I really am because this is just such a devastating way to spend a day. It must be very difficult for you, in your position, to go through days like this. I imagine it's a compilation of days; I'd hope it is a compilation of different days.

**Ms Mableson:** Not all the time, no; some days are like that.

**Mrs Haslam:** Are there any success stories that you could share with us as an add-on to this type of typical northern small-town time?

**Ms Mableson:** I guess what comes to mind is the success that women in my age group are having in stopping smoking. We're not talking about women who are in a high-risk age group, the 12-to-19-year-olds. Those are the kids I'm really concerned about. Women in my age group are stopping smoking, but unfortunately most of them are well past the childbearing age. They've been through it and they can reflect and they know that they have to change their behaviour, but I'm worried about the young moms and I'm worried about the children.

**Mrs Haslam:** Do you think that limiting access to the areas where you may purchase smokes and looking at the cost of cigarettes are two of the strongest preventive strategies we could put in place?

**Ms Mableson:** I think that would be an effective start. I only know what I see and what I live. I hear kids talking. The other day when the new federal tax rollback came out I overheard two young kids talking and the little boy said: "Gee, this isn't going to be so tough any more. I don't have to spend all my allowance here." In Shoppers Drug Mart, standing in line, two young girls, one girl says to the other, "Didn't you know that they're cheaper now?" The other one says: "That's great. I can afford more."

**Mrs Haslam:** I was hoping we could end on a good note. Maybe there just aren't any good notes and it will make us work harder to be sure we can combat effectively what's happening.

**The Chair:** Parliamentary assistant.

**Mr O'Connor:** Thank you for your presentation. You do have a nice style in the way it's presented. The question I have for you would be, what role do you see the public health unit then playing in enforcement and education?

**Ms Mableson:** I think that the public health unit plays a very important role in education. As you probably know, it's a three-part approach: There has to be the education and the legislation and there has to be the enforcement, of which, by the way, there just isn't any where I live, and I'm sure that's true in most small northern towns. Enforcement, there is none right now. There isn't any.

Our tobacco use prevention program at the health unit is growing stronger all the time, and we work very hard in the schools to carry out a large percentage of that education. We use materials that are available through the Canadian Cancer Society, the lung association and other groups across the province and the country. There's no shortage of readily available, up-to-date information, and we really try to do our part in that area, I think.

1520

**Mr O'Connor:** There's actually quite a bit of information through the different clearing houses and what not, but it's always taking a look at something new and fresh that might be coming out from one of the other communities in the province, and they may be tailoring

it just a wee bit to the needs of your local community. Thank you.

**The Chair:** Thanks very much for coming before the committee this afternoon.

FORT WILLIAM COLLEGIATE INSTITUTE

**The Chair:** I'd like to call on Gillian Batay-Csorba from Fort William Collegiate Institute. Thank you for coming and joining us this afternoon. We've got a copy of your written presentation. Gillian, please go ahead with your submission.

**Ms Gillian Batay-Csorba:** I would like to start off by saying thank you for letting me speak in front of such a prestigious committee on behalf of Fort William Collegiate Institute.

Speaking on behalf of teenagers alike, it would be impossible to deny the fact that we are very impressionable, both with the things that we see and hear around us. On the advertising side of this, I think that the idea cigarette companies would like us to feel is what happens when you smoke. The high-class, worldly society of the smoker is very much an idea of what a high school student would like to feel. I can't say with any more disgust than I already have that this is not what happens.

When I was getting ready for this presentation I went to many different classes, and right now at the present time there's a group of grade 8s going to my school because there's an overloading at another school next to us, so we have grade 8 students. My principal and vice-principal gave me a chance to speak to them as well. The majority of those classes of 11- and 12-year-olds smoked. When I went to the grade 9 classes it was the same thing. In grades 10, 11, 12 and OAC it just got worse as it went up.

The majority of smokers, I feel from my research, are part of the younger generation, and I feel that the warnings on cigarette packages are inadequate to inform the youth of what actually happens when you smoke. To teenage girls especially, boys as well, it's very important in high school what you look like. If the cigarette packages let on that your fingers would be yellow, and your teeth and possibly your lips, that you would smell very awful and at one point you cough a lot and it becomes very hard to sustain cardiovascular endurance during aerobic activity, I don't think smoking would have such an appeal after that.

But instead they say, "Well, smoking could harm a pregnancy." Not too many high school students are pregnant at the moment and not too many of them are fathers, so that doesn't really hit them. You speak about lung cancer and emphysema: We're young right now and very ignorant, and I just don't think that has anything to do with us at the present time, so nothing that we could take into deep consideration.

Some people say that they will decide not to smoke and make it the healthy choice, but if you go to any restaurant or entertainment centre except for a designated few, you find it very difficult to find one with a non-smoking section. Even if you do, what says that the smoke isn't going to drift? Then you come to the point, "Well, it's not really my decision on whether or not I

want to be healthy if everybody's going to be smoking around me and I'm just going to be inhaling it."

I'm not passing judgement on the people who do smoke. I'm just saying that maybe if everybody worked together to stop the future generation from smoking, we'd get somewhere. The only people who can save the smokers right now are themselves, but maybe we can extend the courtesy to the younger generation of giving them the decision on whether or not they want clear lungs.

**Mrs Haslam:** That's the most ingenious suggestion I've ever heard. You're absolutely right. We look at the ads and they scare us, you know. This ad for Virginia Slims just scares the bejabbers out of me when I look at the young people and they're saying, "If you always follow the straight and narrow, you'll never know what's around the corner. Be decisive. Be fun. Be active," the ripped jeans, the whole bit. This is geared to you, and I'd love to put right under it, "Yes, you know cancer's around the corner." I agree with the gentleman who brought this.

But the idea of the Surgeon General's warning, "Smoking causes lung cancer, heart disease, emphysema and may complicate pregnancy," you're absolutely right and I love this. It's called truth in advertising. It says, "It will turn your teeth yellow, and your fingers, possibly your lips, and also you'll smell. After a certain period of time you'll find yourself coughing frequently." I think that's the best advertisement we could ever put on cigarettes for young people. Yes, "Kissing someone who smokes is like licking an ashtray." Why don't we get more truth in advertising? I think it's one of the best suggestions I've seen in a long time, and I just wanted to commend you for coming forward today. Thank you very much.

Let's be pessimistic. We're getting very pessimistic. Let's be pessimistic and they're not going to come forward with those kinds of things on packaging. They're not going to take your and my suggestions. Albeit we don't know why, they're just not going to listen to you and me. What else could we do for the young people? What else could we say to young people, what other message, since "You're going to die" doesn't seem to have that much effect on people? People think they'll live for ever at 16. It's only when they get to some of our ages that they start to worry about dying. What other message could we give the young people that would make it very clear it's not cool to smoke?

**Ms Batay-Csorba:** I've thought about that many, many times and I can't come up with any other reasons. I mean, if you tell a child—

**Mrs Haslam:** Young adult.

**Ms Batay-Csorba:** Yes. If you tell us that it's not socially acceptable to smoke, it provokes us to do it. We want to be socially unacceptable. But if you tell us that it makes our appearance look terrible, then it will. But if we can't get across the message on actual packages or in the magazines—I mean Cosmo and Vogue and Seventeen and Sassy, every magazine you look at for a young lady tells you to be beautiful and thin and right next to it is a smoking ad with all these beautiful, thin women having



all this fun that everybody would like to be enjoying—I really have no other suggestions.

**Mrs Haslam:** It's very difficult.

**Ms Batay-Csorba:** Yes.

**Mrs Haslam:** You've obviously done a lot of thought on this, and I just want to say thank you very much. I really appreciate you coming and I know the rest of us are very pleased to have you here today. We're quite impressed with your ability to put your message across.

**Ms Batay-Csorba:** Thank you.

**Mr Carr:** Thank you very much also for coming in. A lot of the people who are your age and smoking, are they buying it legally or is a lot of it illegal? What would you say where most of them are getting them from?

**Ms Batay-Csorba:** Most of the people I talked to get it at the Indian store near Chippewa where they're sold for \$5 for 25.

**Mr Carr:** So they're buying it on the cheap, the cheaper ones. What impact do you think, with the high cost—and I guess some of the people around your age are working part-time. Is cost a factor in the decision to smoke or are they going to smoke regardless of the price, do you think?

**Ms Batay-Csorba:** I think, and from what the majority of people told me at my school, if somebody wants to smoke they're going to smoke. If they have to steal the money, if they have to steal the cigarettes, they're going to get them. Cost may matter somewhat, but to the majority it really doesn't.

**Mr Carr:** And with the changes with this bill, and it probably will go through, do you see a real decrease in the amount of young people starting to smoke?

**Ms Batay-Csorba:** No. In fact, just the opposite. I think more people are beginning to smoke right now.

**Mr Carr:** What about with the bill coming through? Do you think it will help, have much of an impact?

**Ms Batay-Csorba:** Honestly, I think everything that's happening with pharmacies and prices and everything like that, the age increase, I think it will help a per cent but I honestly say that it will be a small per cent. If somebody's going to want to smoke, they're going to smoke.

**Mr Carr:** Good luck.

**The Chair:** Thanks very much for coming down to the committee this afternoon. We appreciate it.

CANADIAN CANCER SOCIETY  
NORTHWEST ONTARIO REGION

**The Chair:** If I could next call on the representatives from the Canadian Cancer Society, northwestern region. Welcome to the committee. If you would be good enough just to introduce yourselves. We have a copy of your written submission and once you're settled please go ahead.

**Ms Lynda Kvarda:** Good afternoon. On behalf of the Canadian Cancer Society we would like to thank you for coming to Thunder Bay. We appreciate your taking the time to listen to our community's concerns about this important issue.

I would like to introduce Dr Geoff Davis. He is a

medical practitioner in Thunder Bay and part of the medical affairs committee of the Ontario division of the Canadian Cancer Society.

My name is Lynda Kvarda. I'm a volunteer for the Canadian Cancer Society, I'm a nurse and I'm a mom of two teenagers. I work in a local hospital. I joined the Canadian Cancer Society five years ago because I felt there was a need to educate our young people against the hazards of tobacco.

In that time we of the health promotion committee developed and presented various anti-smoking programs in the schools across northwestern Ontario and to all the grades from primary to grade 10. I found it frustrating to note the statistics put out by the tobacco resource/action centre indicating a high incidence of children smoking in northwestern Ontario compared to the provincial average.

It's very disheartening for us as educators. Thunder Bay city itself I think is equivalent to the provincial average. It's the smaller communities outside of Thunder Bay that are higher. The study indicated 40% of grades 9 and 10 regionally are smoking.

**1530**

I was delighted when the Ontario government put forth the proposed Bill 119 and I commend you on it. I feel education alone, however, is not enough but that enforced legislation to prevent young people from purchasing cigarettes is pertinent and necessary.

A study, which I'm sure you're aware of, of four northern California communities designed to examine the effects of community education and law enforcement intervention on illegal tobacco sales to minors concluded that education alone had a limited effect on reducing tobacco sales to minors. I have that report with me.

For example, the positive effects of education, combined with law enforcement, have been shown by an increased number of people wearing seatbelts and a decrease in drinking and driving because of the RIDE programs. Those are two examples.

In Bill 119, I am concerned about the phrase, "No person shall sell or give tobacco to a person who appears to be less than 19." "Appears" is too broad a term and allows retailers an excuse for not checking ID. All young people should be required to produce ID credentials which include age and a photo, the same credentials that are required in purchasing alcohol.

Several young girls I know who are 15 and 16 have no problem at all getting cigarettes. They get them from the corner store; 93% of kids who are smoking today get their cigarettes from the corner store, incidentally. Many young girls today look older than they actually are. I have a daughter at home who's 16 and looks 21.

I do know that they have trouble getting cigarettes at the 7 Eleven stores. They have a strict policy, and they abide by it, that they do not sell cigarettes to minors unless they have the appropriate credentials.

One of the most important interventions in preventing young people from smoking is plain packaging. A study funded by the Canadian Cancer Society found that packaging is an important status symbol for young people who smoke. Plain packaging does not give the same

impact. It is also a deterrent for those who want to start. This should be included in the proposed bill.

The study was conducted with two of the most popular brands of cigarettes that kids smoke today, du Maurier and Player's. In part of the study the young people were given a list of adjectives to describe the people who smoke brand cigarettes compared to the people who would smoke plain package cigarettes if they were on the market. The buyers of the brand cigarettes were smart, fun, popular, outgoing; the plain package buyers were considered wimpy, goody-goodies and losers.

It was also noted that the buff-coloured plain packages were more undesirable than the white packages. The white packages were neat and clean and new looking; the buff-coloured packages were old and antiquated and deathlike looking.

Also in the study, the kids were asked what policies or interventions would prevent kids from smoking. They listed cost obviously. It's a good reason for eliminating kiddie packs, I think. The second was the lack of availability through restriction of sales and the third was plain packaging.

In conclusion, I would like to thank you again for coming. It is an important issue, one I feel very strongly about. Seeing someone dying of cancer of the lung or one of the associated diseases is very heartbreaking. It can be prevented and you can help. Thank you.

**Dr Geoffrey Davis:** Thank you, Mr Chairman and committee members. I'd like to further dwell on some of the points that Lynda has made, but also some of the specific suggestions that the cancer society has with respect to Bill 119. Furthermore, I would like to talk a little bit about the issue of chewing tobacco, which is one of the less talked about issues in terms of smoking itself.

I must say that I'd commend this government and this committee for looking, as they have, into Bill 119. I think it's a bill which supports health, not economics. It's a bill which looks to the future. It's a bill which is an insurance policy for our children, which is in itself a very unselfish thing.

I must say that it is with some regret that I'm talking to a provincial committee today, as I think that a lot of people would prefer to be speaking to a federal committee with the very backward step that they've taken in the last week. Just on my way over here, they're talking about all the stores in Hull having a great deal of difficulty keeping up with the supply of cigarettes and that the wholesalers are having to work overtime. We have a domino effect among our provinces, where now provinces are being split with the economic devastation that this federal government has imposed on us.

None the less, if I could speak more specifically to Bill 119, there are several areas, as you know, which we feel could be further enhanced. Lynda has spoken of the phrase "or on other reasonable grounds" in section 3(2) of the bill, an area that should be eliminated from this section, as it is too vague and allows too much latitude in the defence of a person who is dispensing cigarettes to minors.

In section 9, which deals with the places where

smoking is prohibited, we feel that this should be expanded to include the grounds of schools and day nurseries etc.

Regarding packaging, Lynda has spoken about plain packaging and I would like to further mention this issue. If you read the study that was done on the image that tobacco products present when they are presented with the flashy packaging that is there, it's a very difficult study to do. If one reads the study, I think you'll find that it's a very well done prospective study that tried to address the issues in a very responsible fashion.

One of the interesting things that was discovered in their study was that if you looked at the younger teen-aged children, they're more responsive to advertising and promotion of image products, whereas the older teenagers, even at that age, are less influenced by the packaging and are more influenced by the product that they perceive to be better.

Furthermore, on the packaging issue, Mr Chairman, I brought for you a small gift, if you will, to show you the image of packaging as I further discuss chewing tobacco. I don't know if many of you have ever indulged in the chewing tobacco habit, but you might be interested to see some of the types of packaging that are used.

**The Chair:** If it's all the same to you, you can keep the gift.

**Dr Davis:** This is a pack of chewing tobacco which the person over 18 in this province is now allowed to buy. This is the package that the eight-year-olds and 10-year-olds buy. It's called Big League Chew, same packaging, obviously marketed to indulge the children. If any of you parents are parts of sports organization, you may know of the incidence of tobacco chewing in athletes. The younger sports kid goes for this, because their coach will often chew the tobacco. This is another package of smokeless chewing tobacco. This is a package of chewing gum. It's obviously marketed to an early start program, and I think this legislation should look to expanding a ban on chewing tobacco altogether.

The incidence of chewing tobacco is relatively small in this province at the present time, but if you look in some of my abstracts, there are several articles which are referred to there. There's very little literature in Canada available about the incidence.

One of the articles talks about the incidence of college and varsity and intramural basketball players. Of 284 players, 25% indulge in chewing tobacco or smokeless tobacco products. The mean age was 15 for the initiation of all products.

1540

In a larger study of 2,189 grade 1 through 12 students in Pennsylvania, approximately 20% of the subjects reported using snuff, while 16% were already using chew, and of that population 30% smoked.

If you look at the numbers that you've heard here today about our local population, you can pretty well extrapolate that and find that the incidence is very high of chewing tobacco use and will continue to rise within this province. I urge you to look further into the chewing tobacco issue.



With respect to kiddie packs, this legislation must prohibit the sale of kiddie packs as this is a very effective marketing tool targeted only at children in the lower socioeconomic groups to buy smaller quantities of cigarettes in an attempt to addict them at an earlier age.

Tobacco retail licensing is also an issue which you have heard about in previous presentations to this committee. I speak to it once again only to support the previous presentations about retail licensing. It is a more effective means of obtaining control on the sale of cigarettes in that it would provide income for the enforcement and inspection of the rules regarding the sale of tobacco products and, as well, would point out to the owner the added onus on their responsibility in selling the tobacco products.

Lastly, with respect to the issue of pharmacies, we support the ban on the use in pharmacies. However, in reading through Bill 119—I realize this will be dealt with in the regulations coming from 119—we feel the term “pharmacies” must be more clearly defined in terms of what constitutes a pharmacy. Certainly in this city, and I’m sure in many other cities, large supermarkets, supermarkets etc have pharmacies located within them. We would certainly support the ban on the sale of tobacco products in all of those institutions. However, it is not one which we find terribly well explained in the present status of Bill 119.

In conclusion, we’d like to thank this committee for listening to our submission. We believe Bill 119 can be further enhanced to improve the health of individuals. Collectively, by ensuring that this legislation is proclaimed and enforced, we are all fortunate to have an opportunity to alter harmful behaviour and to prevent illness and death caused by tobacco and to reduce the human and financial costs associated with tobacco consumption.

Thank you very much. Mr Chairman, are you sure you wouldn’t like this? I might pass them around, if you like.

**The Chair:** Pass them around, yes. If you have any spare spittoons with you, that might be useful.

I want to just note as well for the record that you indicated at the back of your submission some abstracts on those publications. That is very helpful.

**Mr McGuinty:** Thank you very much for your presentation. I’m interested in learning a little bit more of the incidence of chewing tobacco use by young people. Are there any numbers on that and whether they’re growing?

**Dr Davis:** I don’t have any numbers on the incidence in Canada. Those facts that I spoke to talked about varsity teams. Particularly, it’s a very popular item in the lower socioeconomic group and in the athletes. It’s a popular and a growing area there. I think there are other reasons why it might be more enhancing to children too. It’s obviously a lot easier to hide from your parents. It’s small, it’s compact, it’s innovative, it’s new, it fascinates the children. Much like cigarettes, it’s a little bit disgusting when you first start, but if you continue to try, you can learn to enjoy it.

**Mr McGuinty:** In terms of the hit you get from this

stuff compared to cigarettes, is it cheaper to buy this? If I’m a frugal-minded smoker and I’m merely concerned about price, can we drive people on to this stuff?

**Dr Davis:** I’m sorry. I can’t hear your question with the fan directly above me.

**Mr McGuinty:** The physiological hit you get, is it comparable to cigarettes, first of all?

**Dr Davis:** I don’t know exactly the answer to your question. But cigarettes, I am sure, would be a faster hit because of the fact that cigarettes go directly to your bloodstream through your lung; it takes about seven seconds. It’s faster than intravenous heroin. Chewing tobacco is going to get absorbed through the mucosae of the mouth, so the hit or that pulsatile high that you get from cigarettes will be faster.

If you speak to people who chew tobacco, they say they get the same hit from it. As soon as you show them that pack—I did show this package to a person yesterday who chewed tobacco. He says, “I wasn’t going to chew tobacco all day today, now you’ve really got me going.” That was his first comment.

**Mr McGuinty:** I had heard that the manufacturers actually in some cases put finely ground glass in chewing tobacco to act as an additional abrasive. Have you heard of that?

**Dr Davis:** No. I know that in certain Third World countries they use lye and other abrasive components that may be—I don’t know if that’s in those products—but it may be in other Third World countries they use different abrasives to help induce the impact.

**The Chair:** We’re all going to be ill. Mr Wiseman.

**Mr Wiseman:** I’m asking you if you know, if you can clarify this, but I heard that the minor league sports baseball teams had the rule in place that they’ve banned chewing tobacco in and around the games that are being played in AAA ball or something like that and that they’re trying to get rid of this chewing tobacco.

**Dr Davis:** I don’t know about AAA ball leagues and things. I’m sure there are areas where it probably is banned. But as in the whole anti-smoking, anti-tobacco lobby, if you will, often it’s the legislation that gives other organizations the clout to be able to say, “We have the support.” From a legislative point of view, it’s certainly the members of Parliament and the MPs that one looks to for the leadership to say, “This is where you should go.”

I am sure there probably are areas that have banned it, but again there are probably areas that wish they would ban it but it hasn’t been able to come to fruition because of lack of legislation.

**Mr Wiseman:** Do you have any idea—maybe you said this and I missed it—of the percentages of people who actually use chewing tobacco? It’s way down from what it used to be.

**Dr Davis:** But it’s growing.

**Mr Wiseman:** It’s growing again?

**Dr Davis:** It’s growing rapidly in the United States. There are no studies that I know of in Canada, but the incidence in the United States has been growing very

rapidly.

**The Chair:** Thank you both for coming. I think it's the first time we've talked in some detail about chewing tobacco, and that has been an eye-opener.

**Mr O'Connor:** Thank you for the information. Do you know of any Canadian statistics on smokeless tobacco?

**Dr Davis:** No. I keep getting asked for it. Almost all of the American statistics that you will read will start with, "There is insufficient research, this is a very underresearched area," etc.

**Mr O'Connor:** One in four varsity athletes: It just stands right out.

**Dr Davis:** I think that's pretty consistent across the country in the States. I can show you several other studies that will come with similar numbers. It's not a trivial preoccupation, and if you watch any baseball game, you can see where a lot of the influence is coming from.

**The Chair:** We want to thank you both for coming. I suspect, Dr Davis, you do a number of public presentations and I would be only too happy to give you back this wondrous gift that you have presented to me. Thank you both for coming. We appreciate it.

1550

#### ONTARIO PHYSIOTHERAPY ASSOCIATION, NORTHWESTERN DISTRICT

**Ms Diane Hiscox:** I am representing the northwestern district of Ontario Physiotherapy Association today. I am also speaking on behalf of myself, so that's why you have two documents before you.

I don't have the stats, but just to comment on our previous speaker, I would like to share with you a personal experience about chewing tobacco. I didn't realize that would be an issue here today. My son went to school in Austria. He was a ski jumper. The children there were 15 and 16 years old, and he was telling me that they all chewed chewing tobacco. It was very popular, it was part of the sport, and I think they did it in school. I just thought I'd share that with you.

The first issue that I'm going to address is on behalf of the Ontario Physiotherapy Association. Just to give you a little bit of background about myself, I am a practising physiotherapist and I work on the pulmonary-respiratory service, so I'm very familiar with the clientele, the patients and the people who have suffered the ill effects of tobacco.

As a practising health care professional in the field of physiotherapy, we acknowledge and congratulate the government for its proactive approach to Bill 119. We respect and admire those individuals who've had the courage of their convictions and their values, thereby promoting the health and wellbeing of the young generation of our society.

We as citizens, as well as health care practitioners, have the responsibility to create an environment that promotes informed decisions on healthy lifestyles and behaviours. We support section 3 of Bill 119, which raises the age for the legal purchase of tobacco from 18 to 19.

As you are aware, Ontario's chief medical officer of health stated in his report in 1992 that people who reach the age of 20 as non-smokers are unlikely to become smokers. The addiction of the vast majority of smokers begins in teenage years. I might add at this point that a lot of people I see in my practice started smoking at a young age. When I speak to them, they were not aware of the ill effects of smoking, or else they only associated them with cancer, not with being in the hospital, tied up to an oxygen line and losing their freedom.

According to Addiction Research Foundation statistics between 1977 and 1991, the percentage of young people trying tobacco for the first time before grade 9 dropped from 89% to 69%. However, that percentage increased from 69% to 75%. I do not need to tell you this; you've heard it today. But what I suggest you do is go to your local school yards, your junior highs, your high schools. Those of you who have teenagers, ask them how many of their friends are smoking, and I think you'll be a bit amazed, if you're not already.

We believe that tobacco sales in health care facilities, pharmacies, retail establishments linked to pharmacies and prescribed places should be prohibited. In agreement with the framework of the health promotion model, as presented by Jake Epp in 1986, Achieving Health for All, Bill 119 supports healthy environments and facilitation of self-care. Jake Epp's report embraces health promotion when discussing a new vision of health. It identifies prevention of illnesses as a national health challenge, stating that preventive measures can lead to a 50% reduction in the incidence of lung cancer and heart disease.

Health facilities and pharmacies that sell tobacco products are sending and giving mixed messages about the risks of tobacco. Indeed, these facilities should be part of the solution, not part of the problem. The document Achieving Health for All supports Bill 119. Now we must consider whether we will accept the challenge. We must walk the talk.

We strongly encourage the government to continue to pursue section 5 in that tobacco sold to the consumer retailer must be packaged in accordance with the regulations. This package is to bear both health warnings and other health information. The cancer society—and you've heard all the research that it has given—certainly indicates to us that the public policy to legislate plain packaging is part of a comprehensive plan to reduce tobacco use. By excluding plain packaging from such a plan, an important opportunity would be missed to effectively break a critical and powerful link that transfers the images portrayed via other promotional strategies to the user of cigarettes.

In summary, as health care practitioners, physiotherapists of the northwestern district of the Ontario Physiotherapy Association, we totally support Bill 119 to make the public cognizant and better-informed citizens about the risks of starting smoking, particularly at an early age.

I brought with me, if you wish to see it—I'm sure you're familiar with it—the report. This bill certainly supports that.

The next submission is a personal submission. I just



want to illustrate to you the impact that smoking has.

I would like to describe to you a prominent citizen in our community who started smoking about 35 years ago. Those who are in my age group will be aware that in those days smoking was not considered a very dangerous thing to do; it was the in thing to do. The marketing wasn't as slick as it is today, but it was quite fashionable, without risk.

This person stopped smoking when his child was born—that was about 13 years later—but he did not give up his pipe. We were led to believe that pipe-smoking just caused cancer of the lips, so it was a treatable illness and we all bought into it. He pursued a career in neurosurgery. He came to Thunder Bay and was the only neurosurgeon. This man was a very dedicated neurosurgeon. He didn't miss one day of making rounds in a hospital in 27 months.

He was able to obtain a partner. They practised neurosurgery together and provided very good service to their patients. However, he practised in a smoke-filled office, part of it being that he contributed to it. He practised in a hospital where smoking was allowed in those days.

This man died 18 months ago of cancer of the lung. That means in Thunder Bay we have one neurosurgeon left. That means that when he takes holidays, for this community there is no coverage. A child could die of a head injury; a pregnant mom could get in trouble. There is no neurosurgeon between Kenora and Sault Ste Marie. For people who live in the north, that's fairly significant. If you're aware of the political situation with doctors, recruiting a neurosurgeon is not easy.

He also left four children and a wife. I am the wife. I've paid the price, the community has paid the price, of what cancer can do. I'm a physiotherapist; I bought into it. He was a neurosurgeon; he was addicted. That's the kind of impact that smoking has. You can talk about your stats, but when you have to deal with it, it becomes a very important issue. There's a lot of responsibility here in the decision that you are making.

I thank you for giving me the opportunity to share my feelings with you today. I hope I will have some impact on the decisions that you are forced to make. I know the decision will not be easy for you; there are many ethical issues here. But I think we have a responsibility to our children. People don't like to give rules to children. Children like structure. You find the happy children are in an environment where there are structures and there are limits set for them.

Thank you for allowing me to make my presentation today.

**The Chair:** Thank you for your submission—I think everyone feels very strongly—and in particular the personal submission that you made. As you say, so often we look at this issue in terms of data and statistics, all of which are important and meaningful, but we also have to remember the real people behind those statistics. Your presentation is all the more effective because of that, although we all share with you in wishing that you had never had to make that particular submission.

**Ms Hiscox:** Are there any questions? I'll entertain any questions.

**The Chair:** I think, quite frankly, your submission stands by itself. We want to thank you very much for coming here this afternoon.

1600

BRENDA ADAMS

JOHN GINN

**The Chair:** I now call on the next witness. Just to note for members of the committee, there are two: from Shoppers Drug Mart, Brenda Adams, and from Canadian Safeway Ltd, John Ginn. Welcome to the committee.

**Ms Brenda Adams:** My name is Brenda Adams and I'm pleased to have the opportunity to speak to you today. I'm sorry I don't have copies of my submission, but I will provide one to the committee within a few days. With me today is John Ginn, the manager of the Safeway store on Arthur Street here in Thunder Bay. His 50,000-square-foot store also has a pharmacy.

I would like to welcome you to Thunder Bay and I hope you enjoy your time here. We are very proud of our community and I hope you will get a chance to see some of the city. I also hope I will be able to bring to you a new perspective to some of the issues that you are addressing in this hearing. I know it has been a long day, so I will keep my remarks to the allotted time.

I wholeheartedly support the government in working towards a smoke-free society in Ontario. The steps you are initiating in Bill 119 will go a long way to ensure that young people do not start smoking and that the sale of tobacco is controlled. It is very clear that this government is concerned about the health care of Ontarians and this legislation reflects that concern.

There are a lot of good initiatives in this legislation. This government should be congratulated for the public policy direction. However, in the context of this issue, there is no place for a ban of sale of tobacco in pharmacies. It will not help the government achieve its broader goal of better health care and is unfairly punitive to pharmacists who presently choose to sell tobacco as part of their regular retail products.

Many of the presenters in these hearings tried to lump all the pharmacies into one format, typically that of a very traditional, old-fashioned pharmacy. In Thunder Bay we have many different types of pharmacies. We all have different types and shapes of pharmacies. We have a Zellers Pharmacy at the Intercity Plaza, a pharmacy in the Safeway supermarket, and the Canadian superstore that has a pharmacy as well.

I own and operate two Shoppers Drug Mart pharmacies. I think I can help you understand that all pharmacies are different and require different product offerings due to their format and to their dependence on physicians.

One of my pharmacies is a 6,000-square-foot store located in Centennial Square, and I sell tobacco at that location. Tobacco makes up 13% of my sales. My store is configured like many other Shoppers Drug Marts. We merchandise the tobacco in a 12-foot section at the front checkout. There is absolutely no other product that I can

add that will only require 12 feet of space that will generate 13% of my sales.

Keep in mind that tobacco has an even greater contribution to sales than my entire cosmetics department and it's equivalent to my combined sales of paper products and confectionery, or to my total sales of over-the-counter medications which, I might add, are also sold by my non-pharmacy competitors.

This legislation is just the same as if you told me I could no longer sell cosmetics or paper products and confectionery or over-the-counter preparations. To me, as a retailer and as a business person, it is the same issue. These products are all departments within my store. You can see that I rely on tobacco for a large percentage of my sales, as well as the companion purchases that are made by customers who come in to buy tobacco.

My other pharmacy is totally different. It is in the Port Arthur medical clinic and we do not sell tobacco at that location. It occupies only about 2,000 square feet and there are approximately 40 doctors in the medical building. As a result, our business is almost exclusively prescriptions. We have a very small front-store business and no competitors in the immediate area. I do not need tobacco at that location to survive.

As a pharmacist and as a retailer, I can tell you these two stores are completely different for many different reasons: because of their size, their location, the competition that is around them and because of their proximity to doctors, and also based on their reliance on tobacco sales.

Many pharmacists who operate small medical centre pharmacies have appeared before this committee to proudly declare that they have dropped tobacco and have not suffered economically. Some may go on to recommend that all pharmacies should be prohibited from selling tobacco. It is no wonder that they have not suffered economically, but they should not unduly influence your decision. In essence, a pharmacy ban would give a small medical centre an even greater advantage over other pharmacies that are not located in the medical centre.

I have recently seen a copy of the Coopers and Lybrand study that was presented to you last week. I found it very interesting because it confirms what I'm saying, but also it demonstrates how important and fragile pharmacies in northern Ontario are. According to the study, over 2,700 full- and part-time jobs in Ontario will be lost, and from 120 to 140 pharmacies will close if they are prohibited from selling tobacco. In northern Ontario 196 pharmacy jobs will be lost and 10 community pharmacies will be closed.

It also details the impacts this will have on access to pharmacy services. In northern Ontario the potential market area without a single pharmacy would be over 43,000 square kilometres. I've been involved in many local pharmacy groups and I can tell you that we cannot afford to lose 10 community pharmacies in the north. There will definitely be whole communities that will no longer have a pharmacy service, especially in the north, as a result of this legislation. There are even some northern communities that are providing grants to pharmacists to come to set up pharmacies in their town. This

legislation will definitely hurt these communities.

Just an aside—nothing that's in my notes here today—I really feel like I'm the bad guy here today, and I'm not. I'm a health care professional along with the rest of us. I'd really like to see tobacco non-existent. All I'm asking you is not to pick on pharmacies. If it's something that you want to legislate not to be sold, it should be made an illegal substance and not be available to anyone. To that I'd stand up and cheer, but I don't feel it's fair that I be singled out as one single retailer where tobacco should be banned. I'm in business like others.

At this time, I'd just like to pass it on to John to say a few words and then I'll say a little bit more.

**Mr John Ginn:** Thank you for allowing me to speak. Our regional manager was supposed to have made a presentation but couldn't make it, so I decided to come along with Brenda as I am very concerned with the clause that contains the pharmacy ban within Bill 119.

I won't take too much of your time. I only want to make a couple of key points. The pharmacy in my store is 1,500 square feet. That is only 3.5% of my total store. I have professional pharmacists on staff who have the dispensary under their supervision. They have nothing to do with the remainder of the store where the tobacco is sold. Those pharmacists serve their customers well and provide a valuable health care service to the shopping public who frequent our store.

If our company is forced to choose between the sale of tobacco and the pharmacy, that decision will be based on which is the largest contributor to the overall operations of the store. With the shrinking margins within pharmacy brought on by cutbacks to the Ontario drug benefit plan, I would have to guess the pharmacy would be the one to go. In my store that is five people; multiply that by the 151 non-traditional store formats in Ontario and you have a large number of unemployed people who won't be rehired by those stores to stock produce, meats and general merchandise etc. Thank you for letting me say my piece.

**Ms Adams:** I've also been following the federal tobacco legislation that relates to these hearings. The recent announcement by the federal government to a large extent is a mirror image of Bill 119. It seems that they have taken most of the provisions of Bill 119 into their own legislation. There is, however, one glaring difference, and that is the issue of sale of tobacco in pharmacies.

The federal government is completely silent on the issue of pharmacy sales. They recognize that there is nothing to be gained by a pharmacy ban and that it is discriminatory and likely unconstitutional to prohibit one type of retailer from selling a legal product.

**1610**

I know you've heard presentations from the Ontario College of Pharmacists which state that it does not represent the business or economic interests of pharmacists, and it doesn't. As a professional issue, there is no argument with their position but this is as much a professional matter as it is an economic issue.

Simply put, I need tobacco to pay my rent, salaries and



overheads to operate my business. If you legislate tobacco out of my drugstore you will force me to terminate at least four members of my staff at the Centennial mall location, and that's not an exaggeration. In fact, I was going to invite those four people here today and let you tell them that their termination would be a direct result of your legislation. My colleagues at the other three Shoppers stores here in Thunder Bay would also have to terminate people from their stores. Those terminated will be primarily women, part-time students and new Canadians. Surely this is not a group on which you wish to visit further hardship.

I know that you think you are doing the right thing, but are you doing the thing right? Will it reduce consumption? No, it won't. Ask yourselves: Will it result in job loss? Will it close down some pharmacies? Will it be discriminatory? Will it be unfair? If your answer to those questions is yes, then why are you doing it? Thank you again for your attention.

**Mrs Haslam:** I've been collecting a lot of data over the weeks on this issue and I find some of the things that are brought in very interesting. One of the people making a presentation reminded us that under the principles of ethical behaviour of the Canadian Pharmaceutical Association, a pharmacist shall not participate in any advertising or promotion program which might encourage misuse or abuse of drugs. As a pharmacist, you would be aware of that.

The other one I found really interesting under the code of ethics was that a pharmacist should never knowingly condone the dispensing, promoting or distributing of drugs which lack therapeutic value for the patient. I understand the concerns of some people who come before the committee who say, "I'm a pharmacist, I'm a health practitioner, but the bottom line is always how much profit I can make in my store."

Some of the other facts that we've had to deal with: Nicotine from an inhaled cigarette reaches the brain in seven seconds, and as a health practitioner, that should be something that does concern you. Tobacco is responsible for 20% of all deaths in Ontario in 1992, and as a health practitioner, I would think that would concern you.

We've had very many interesting people today. One was a 12-year-old boy from this area who brought in samples of cigarettes that he had bought and one of them came from Shoppers Drug Mart. That has to concern us when a 12-year-old is able to go into a facility and purchase cigarettes.

The gentleman before you I think made it a very clear case. It's something that I've been talking about over the extent of this time. This is a bill which shows foresight, as a piece of legislation which is about health and not economics, about saving people's lives and not protecting the incomes of individuals or corporations.

Some of the things that you mentioned—13% of your sales. The profit margin, though, is very low on the cigarettes. It's basically a cash flow in your business that is—

**Ms Adams:** It is a big cash flow.

**Mrs Haslam:** Because you don't pay for the ciga-

rettes.

**Ms Adams:** Yes.

**Mrs Haslam:** You sell them, you get the money, it's a cash flow. So your profit margin on that particular product is fairly low.

**Ms Adams:** It still delivers a fairly good amount of profitability regardless, due to its volume.

**Mrs Haslam:** Right. We've had some people come in who have had 10% of their sales from tobacco, who have taken it out of the stores and have survived, have not laid off people, and I share that with you.

You said that there was some sale of other products and should we then ban other products in your store. I would just point out that cosmetics are not addictive; nicotine, and tobacco, is addictive. We have had health professionals come before us and say that it only takes two to three cigarettes and it is an addictive product. While I can agree that letting you sell certain products might not be to your benefit, I think in this case, we're looking at the benefit of young people and other people.

You mentioned the Coopers and Lybrand report. Did you get this from the Committee of Independent Pharmacists?

**Ms Adams:** Yes, I've seen a copy of the study and I looked it over.

**Mrs Haslam:** Are you aware that out of 1,400 pharmacies, they interviewed 13?

**Ms Adams:** I thought it was over 300. That's what I was led to believe.

**Mrs Haslam:** No, 13.

**Ms Adams:** I thought it was 13 in the independent—

**Mrs Haslam:** I'll let you check the report.

**Ms Adams:** —and 300—

**Mrs Haslam:** You mention that you're singled out. Actually, if you read the legislation and you look at it, you will find that we have not singled out pharmacies. What we've said is all health facilities. You are one of a group of health facilities.

**Ms Adams:** You've singled us out as retailers.

**Mrs Haslam:** No, we singled you out as a health facility perhaps, as a health facility that sells tobacco, but they also sell tobacco in hospitals, which we are now saying cannot be done, in hospitals where veterans are, in other institutions. As a health facility, you are one of many in this legislation.

**Ms Adams:** However, pharmacies are in a unique situation whereas pharmacies aren't what they used to be where they are only a health care facility. They have grown into large retail stores, just like, for example, Safeway that has a pharmacy within it.

**Mrs Haslam:** Yet you come before us in Toronto to look at the Regulated Health Professions Act. The pharmacists came to us and said: "We wish to be part of the regulated health professionals. We are not retailers; we are health professionals." I think that's where the crux of this legislation is. It's a health profession and we have to look at it as a health situation, not just a retail situation.

**Ms Adams:** I agree, and as I said, that is the one profession that does have that conflict of interest where we are health professionals when we are behind the counter but we also have to look after our business and our staff and there is the economic side to it, not to mention the fact of the companion sales we would lose. It wouldn't just be tobacco that's hit.

As I say, I wholeheartedly support the idea of making tobacco an illegal substance. I don't feel the clause banning it within the pharmacies alone or within health facilities alone will decrease the amount of tobacco consumption.

**Mrs Haslam:** I would tend to disagree. I may not disagree. What I know is that there are a number of stores in Sudbury that have reduced their sale and have not had an adverse effect. I know the College of Pharmacists, your governing body, has asked you to do this on a voluntary basis. When that didn't come, they came to us and said, "We need you to bring in this legislation."

I will end with one thing. Comments are often made that this will not help the government reach its goal, and there are many things that have been done in the last week or so that will prevent us, obviously, from reaching our goal in the year 2000 to reduce the number of smokes.

My comment would be: If removing one more access point for the sale of tobacco to young people—and we've had many people come and say and they've done questionnaires and we do know young people can buy cigarettes in pharmacies, that it does happen, and it happens all too often to my way of thinking—if we can remove one more access point and prevent just one more young person from starting smoking, believe me, I think that's worth it.

**Ms Adams:** Absolutely, and I really believe that in my store my staff are very well briefed on not selling tobacco to minors.

**Mrs Haslam:** How many Shoppers Drug Mart stores are in Thunder Bay?

**Ms Adams:** There are six total.

**Mrs Haslam:** So out of six, this afternoon Ryan was able to get into one of them and buy cigarettes.

**Ms Adams:** I'm speaking for my staff.

**The Vice-Chair:** Does that conclude your presentation?

**Ms Adams:** Yes.

**The Vice-Chair:** Thank you very much for coming before the committee with your presentation.

1620

#### ONTARIO SECONDARY SCHOOL TEACHERS' FEDERATION, THUNDER BAY DIVISION

**Mr Kevin Holloway:** My name is Kevin Holloway and I am the president of Thunder Bay division of the Ontario Secondary School Teachers' Federation. I thank the committee and the hearing for allowing me to present this at a later date than originally scheduled. The package that I've presented, a little levy here, is in Valentine's Day red for you. My secretary wanted to make a heart out of it, but I didn't know how well that would go.

I've given you some background to the Thunder Bay division and the Ontario Secondary School Teachers' Federation, OSSTF for short. I do make a disclaimer that this document is not anywhere near an official policy statement by our provincial office. I'm not sure if they have one on the record at this time concerning Bill 119. But it is a collection of observations from educators in Thunder Bay and, as such, I hope you can use it in whatever way you wish.

To start off, I'd like to compliment the progress of this bill and I'm very pleased to support what you have done so far in the legislation. We would like to offer some suggestions.

The main purpose of OSSTF is to advance and promote the cause of education. We feel there is a connection between the health of our young people we work with and cigarette smoking or tobacco use, and as such we feel a need to speak out and state our opinion. Our opinion is that we should try to prevent in whatever way we can our youth from smoking tobacco products. We acknowledge that tobacco is a known killer, and it's our duty therefore to speak out.

In addition to that, there is an effect on part-time work habits. When students need money to finance their use of tobacco—it could be called a tobacco addiction—students often turn to part-time employment, which does then take them away from their time with their studies. This is not the only reason of course that students do part-time employment, but it does have a significant effect on their success.

We feel there is a connection between the health of individuals and their self-concept, and therefore their success in their studies. We want our youth to stop starting to smoke, and we need the legislation that you're proposing in order to help us do our job in the school.

Although we try our best, it is a fact that students do end up smoking on school property. We do our very best to patrol the different areas. We patrol the washrooms, we patrol the vestibules, we patrol the back doors and a variety of areas, hallways and stairwells, and occasionally we do catch students smoking.

What we end up having to do is more of a discipline matter rather than any health-associated matter. We feel that this legislation you're proposing will pretty well state that all of the student population should not be purchasing cigarettes because of the increased age and it will do a lot in helping us enforce the no-smoking-on-board-property rule.

An interesting aside: When the board of education—I guess all across Ontario, but our board—said there is a zero tolerance to smoking on board property for both students and employees, it forced people on to the sidewalks. I wish I could address that, but having students on sidewalks in front of the school or in the bus loading areas on the sidewalks is significant. In some cases, it's directly opposite elementary schools, so elementary schools see high school students smoking and a role model is created. I don't know how to address that, because we can't control what happens on public property. It's just an issue that I bring to your attention.



The school staff try their best to do all the different things. You heard from Brian McKinnon, our principals' and vice-principals' representative. We have programs in our phys ed classes to look at changing their attitudes towards non-smoking. However, students still do smoke.

We feel that restricting the number of retail outlets by preventing pharmacies and health care agencies from selling is a positive move, and of course the vending machines, which do not have a conscience. Vending machines sell to anybody.

We'd like you to suggest a few alternative things you may want to include in the legislation or future legislation. We feel that licensing retail outlets would be a way to have a definite control as to what those sales clerks and sales places would do. We feel that plain packaging would take away the connection of the image students have received through whatever advertising there is and from whatever role models in their lives. Plain paper packaging would be a definite suggestion that we can support wholeheartedly.

The banning of smoking in the public areas and removal of secondhand smoke really is very important, and the educational approach I think should go along with this approach of control. The advertisements we've seen recently on television are very, very good. We must work at countering the image that cigarette smoking is the in thing to do and that the only way to be accepted by your peers is to have a cigarette with them on the bus home or at parties and so on.

I think working together in an educational manner, with the correct kind of advertising, along with the restrictive manner your bill is proposing, is a way we can support, a joint thrust, educational and preventive. So we support what you have here and we'd like to leave this open for questions now.

**The Vice-Chair:** Thank you for your presentation. Are there any questions at this time by anyone?

**Mr O'Connor:** I appreciate your presentation. I know as a politician representing a constituency, quite often we'll get into the schools in our riding, and of course, this legislation being topical right now, quite a few of us are taking the opportunity to get in and talk to the kids. I guess part of the difficulty we have is that of course legislation alone can't do it. We have to involve the community and what not.

In the schools I guess part of the difficulty would be that quite often some of the teachers are smokers, so there's a challenge there again. I guess it's a double challenge. Trying to restrict the view of that is a problem, and not so much as it would be without this legislation in place, because it will be a total ban from the school and all property.

I just wondered if you had any thoughts you might have about how we approach the subject as we go into the schools to talk about it.

**Mr Holloway:** I'd like to comment on the concern about teachers smoking. When I started work with the Lakehead board back in the early 1970s, many people did smoke, and as we've moved through this era of understanding the effects of tobacco and having the restrictions on what we can do on board property, many, many teachers have stopped smoking. The actual executive I'm president of now in the past probably would have had three quarters, if not all, of the union officials heavy smokers. Now there are no smokers involved in OSSTF who are involved in our executive or division council, which is a fairly large body.

Times have changed. People are changing slowly. Of course there are some teachers who still do smoke. They are addicted to it, as many of the kids are addicted to it, but they are cutting back and they try their best to portray a healthy image to the students. Students do know, however, who smokes. Teachers have to have that same nicotine fix that students do, even though they're working against it.

I feel that part of the thing our boards of education could be asked to do is provide not only a punitive thing for students smoking, such as suspension or detention, but some kind of health care change in practice, something to help them stop smoking. I know teachers have the opportunity to take part in an employee assistance plan that has helped them, and there is nothing out there easily available to students. As well as saying it's bad and showing advertisements that it's not good for you, we should have plans in place, though I'm not sure where the funding comes from, that will help people stop smoking.

**Mr O'Connor:** I appreciate that. Cessation programs would be useful, and I'm glad to hear that there's something for the teachers themselves.

There's a booklet put out by the Ministry of Health called Talking it Out. It's a parents' guide to sitting down with the children to try to talk it out, because quite often when children reach that age where they'll start taking up the tobacco habit, they actually are at a difficult stage of life for communicating. Sometimes it isn't the best. I just wondered if you'd seen that documentation. I thought the document itself was fairly well laid out and I just wondered if you'd seen it or not.

**Mr Holloway:** No, I'm not aware of that package, but I'd have to become aware.

**Mr O'Connor:** Perhaps we need to circulate it a little bit better.

**Mr Holloway:** Yes.

**The Vice-Chair:** Any other questions? If not, thank you very much for making a presentation to the committee. That is the final presentation to the committee here in Thunder Bay, so the committee stands adjourned until 10 am tomorrow morning at Queen's Park.

The committee adjourned at 1631.







## STANDING COMMITTEE ON SOCIAL DEVELOPMENT

**\*Chair / Président:** Beer, Charles (York-Mackenzie L)

**\*Vice-Chair / Vice-Président:** Eddy, Ron (Brant-Haldimand L)

\*Carter, Jenny (Peterborough ND)

Cunningham, Dianne (London North/-Nord PC)

Hope, Randy R. (Chatham-Kent ND)

\*Martin, Tony (Sault Ste Marie ND)

\*McGuinty, Dalton (Ottawa South/-Sud L)

\*O'Connor, Larry (Durham-York ND)

\*O'Neill, Yvonne (Ottawa-Rideau L)

Owens, Stephen (Scarborough Centre ND)

\*Rizzo, Tony (Oakwood ND)

\*Wilson, Jim (Simcoe West/-Ouest PC)

*\*In attendance / présents*

### **Substitutions present / Membres remplaçants présents:**

Carr, Gary (Oakville South/-Sud PC) for Mrs Cunningham

Haslam, Karen (Perth ND) for Mr Hope

Wiseman, Jim (Durham West/-Ouest ND) for Mr Owens

### **Also taking part / Autres participants et participantes:**

Ministry of Health:

O'Connor, Larry, parliamentary assistant to the minister

Williams, Frank, legal counsel

**Clerk / Greffier:** Arnott, Doug

**Staff / Personnel:** Boucher, Joanne, research officer, Legislative Research Service



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## Legislative Assembly of Ontario

Third Session, 35th Parliament

## Assemblée législative de l'Ontario

Troisième session, 35<sup>e</sup> législature

# Official Report of Debates (Hansard)

Tuesday 15 February 1994

# Journal des débats (Hansard)

Mardi 15 février 1994

## Standing committee on social development

Tobacco Control Act, 1993

## Comité permanent des affaires sociales

Loi de 1993 sur la réglementation  
de l'usage du tabac

Chair: Charles Beer  
Clerk: Doug Arnott



Président : Charles Beer  
Greffier : Doug Arnott





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## STANDING COMMITTEE ON SOCIAL DEVELOPMENT

Tuesday 15 February 1994

The committee met at 1003 in room 151.

## TOBACCO CONTROL ACT, 1993

LOI DE 1993 SUR LA RÉGLEMENTATION  
DE L'USAGE DU TABAC

Consideration of Bill 119, An Act to prevent the Provision of Tobacco to Young Persons and to Regulate its Sale and Use by Others / Projet de loi 119, Loi visant à empêcher la fourniture de tabac aux jeunes et à en réglementer la vente et l'usage par les autres.

**The Chair (Mr Charles Beer):** Good morning, ladies and gentlemen. Just before we begin the morning's deliberations, I draw to committee members' attention that we have received the second of the summary of recommendations from research and also recent press clippings covering the February 11 to 14 period, for your information.

## ASTHMA SOCIETY OF CANADA

**The Chair:** We have another busy day. Let us begin by calling on the representative from the Asthma Society of Canada, Ms Elizabeth Kovak, executive director.

**Ms Elizabeth Kovak:** Thank you for this opportunity of appearing before you on behalf of the asthma society. We're a national volunteer-based organization devoted to enhancing the quality of life of people living with asthma.

We're very pleased to see what has been proposed in Bill 119. We also want to applaud the efforts of all parties in working together in a non-partisan way for something which is so obviously for the common good.

I'm speaking from two points of view today, first of all, representing the asthma society. Up to 10% of Canadians have asthma. We're now told that 20% of children are diagnosed with asthma symptoms, so it's of grave concern to us.

Asthmatics know that smoking increases asthma symptoms. They also know that if they smoke, they're at much greater risk of developing irreversible airway damage. However, they're often exposed to the dangers of passive or secondhand smoke. There's evidence to conclude that increased severity of asthma and also additional asthma attacks are caused by passive smoking. In the United States, in a study by the Environmental Protection Agency, information indicated that in utero exposure to a mother's smoke can also produce increased bronchial responsiveness, which may predispose children to early respiratory illnesses.

Through our telephone counselling services, we often hear of the deleterious effects of smoke in the workplace and other public places. Sometimes people simply have to leave because of an asthma attack. It causes severe discomfort, but it also causes attacks, which certainly add to health care costs. We ask that section 9 of Bill 119 be strengthened so that smoking is only permitted in public places so designated and where it has been determined that no harm will come to other people because of this.

I'd also like to speak as a concerned citizen. I've given you some facts in my presentation, but I'd like to personalize it. I started smoking when I was 15 years old. I started because cigarettes were cheap, they were very easy to get, and because it was so cool to be seen to be smoking. I liked the fact that my peers thought I was really sophisticated because I carried that glamorous cigarette package. Now I find that it really wasn't that much fun.

Colon-rectal cancer is the second leading cause of death from malignancies in the United States. Recent studies show that I now run a much higher risk of having colon-rectal cancer even though I haven't smoked for over 25 years. The other part of the study indicates that this risk is fixed for life. Even though I don't smoke, the risk has been fixed and will not stop throughout my lifetime.

There are more things that are being found. Expectant mothers are also at risk. Because I smoked when I was pregnant for a brief time, my daughter, even though she has never smoked, should she become pregnant, runs a 29% greater risk of miscarriage than if I hadn't smoked. So we're looking at health care costs that impact on future generations. If both my daughter and I had smoked, the risk of miscarriage would rise to 60%. These are frightening figures.

The addiction to smoking for most people more than likely started when they were young people. A Health and Welfare Canada study shows that 90% of young smokers started before the age of 17. Of course, this is when I started too. Young people are very sensitive to peer pressure and the need to be cool. The health risks, even if they're told about them, aren't really something they linger over. That's something far in the future.

We strongly support the measures in Bill 119 which will deter people from smoking. Banning of cigarette sales from vending machines and drugstores, increasing the legal smoking age and plain packaging will help to do this. We also support our colleagues in recommending the banning of kiddie packs—where you can buy less than 20 cigarettes—because young people are price-sensitive, and the regulation of tobacco paraphernalia.

The asthma society strongly urges you to consider the measures in this bill. We believe that the implementation of Bill 119 will show the government's strong commitment to preventive health care and will make possible smoke-free generations in the future.

1010

**Mr Dalton McGuinty (Ottawa South):** Thank you, Ms Kovak, for your presentation. First of all, I should make it clear that there's every indication that Bill 119 will receive unanimous support in the House, and that of course recognizes that by and large it's a very good bill.

You've made an important suggestion here dealing with section 9. If I quote from your paper, it says, "We



ask that section 9...be revised and strengthened so that smoking is only permitted in public places so designated and where it has been determined that no harm will be caused to others by the resulting smoke."

First of all, what do you mean by the specific words, "...it has been determined that no harm will be caused to others by the resulting smoke"? What does that mean in terms of the physical setup?

**Ms Kovak:** I'm saying that to allow smoking, the onus should be on the owner of the premises to prove that other people will not be harmed. In other words, great strides have been made in having non-smoking areas, but if you have a smoking area in a restaurant and a non-smoking area, it has very little effect for the majority of people in that restaurant, because they're still breathing the smoke. I'm not a scientist, but I believe you would have to have two different systems to expel the air in the same room to actually allow places for smokers and non-smokers. What we're advocating is that in such places, where you want to have smokers, you have to prove that other people there who don't wish to smoke won't be harmed.

**Mr McGuinty:** One of the things I've noticed, and I'm sure you've noticed this too, is that marketing yourself as a non-smoking restaurant, for instance, has become something that is more and more common, because more and more people have become educated about the adverse effects of secondhand smoke. I gather you're impatient with that progress and you prefer that the law would step in. Am I correct?

**Ms Kovak:** Yes. I think great strides have been made, but there's still much more to do, because we hear of people who go to restaurants and have to leave because of an asthma attack or exacerbation of their symptoms. So we feel that there is still more to do. We applaud what has been done, I think the results are very good, but we think there is still more to do.

**Ms Jenny Carter (Peterborough):** We were listening to a doctor yesterday in Thunder Bay, and he suggested that secondhand smoke is very detrimental, especially to children, and that it could actually increase the number of cases of asthma among children. Do you have any evidence of that?

**Ms Kovak:** It certainly increases asthma symptoms, and the fact that 20% of children now are diagnosed as asthmatic—yes, it will.

**Ms Carter:** Some 20%? That's terrible.

**Ms Kovak:** Yes. The symptoms sometimes disappear as they get older, but 20% of children.

**Ms Carter:** You also mention that 90% of smokers start before the age of 17. We had heard the age 19 mentioned, I guess, so it doesn't make a lot of difference. What would you suggest as the means by which we could minimize that number of children starting smoking? What particular measures do you think would deal with that?

**Ms Kovak:** I think anything that would make cigarette smoking no longer be a cool thing to do. Plain packaging: That glamorous package and the marketing by cigarette companies and the lifestyle are very powerful.

When I was much younger, the Virginia Slims ad in

the US was always with a beautiful girl whose legs appeared to go all the way up to her shoulders. I really liked the way those girls looked and I wanted to be one of them. Smoking Virginia Slims, because I lived at that point near the border, was a very glamorous thing to do.

**Ms Carter:** People feel that if you smoke you will remain slimmer, maybe because you eat less?

**Ms Kovak:** That it lessens your appetite. I think also the availability of cigarettes. Of course it's a long time ago, I realize, since I was a teenager, but no one ever asked my age. I think anyone could go and buy cigarettes. They were reasonably cheap and no one ever asked whether they were for you or for father or whoever. So if they're less available also.

But I think more powerful than anything is to remove that glamorous idea about cigarette smoking. Also, the point of purchase: If the cigarettes are shown in a retail outlet with signage that indicates you have a glamorous lifestyle if you smoke, I think that has an effect on young people. It may have an effect on other people too.

**Ms Carter:** Of course, there are educators in the schools trying to convince children that they shouldn't smoke. We hear that at that age they think they're invincible and nothing they do is going to have a bad effect on them. One suggestion is that instead of the slim young ladies, you show what smoking really does to people, how they look when they've been smoking for a few years.

**Ms Kovak:** Yes. Someone with an oxygen tank beside them would be powerful.

**Ms Carter:** What about another aspect of it, that in fact they are succumbing to manipulation when they take up smoking? If you could demonstrate that, then it would seem that rather than being cool and independent and leaders, they would be just the opposite. Do you think that may be all right?

**Ms Kovak:** Yes, that might be something to stress, that advertising does manipulate us.

**The Chair:** Final question, Mr Villeneuve.

**Mr Noble Villeneuve (S-D-G & East Grenville):** Thank you, Miss Kovak. We certainly all sympathize with the asthma society and asthmatic people, and certainly smoke is one of the no-nos around these people. There are some in my family, so I know all about it.

I certainly will be supporting Bill 119, but I have a problem with having some of the rural pharmacies being told that they cannot sell a legal product that is available across the street from them. I live in an area in south-eastern Ontario where we have Akwesasne next door, we have New York state, and now we have the province of Quebec. We have deliveries made to our high schools. As long as the students have \$22, a carton of cigarettes is very much available to them.

I hope that can be discontinued as soon as possible; however, going with the provision of eliminating the sale in some of our small pharmacies where the front end of the store carries a good deal of the overhead, we may well have some of our pharmacies, hopefully not closing, but certainly suffering a fairly major reduction in their economic ability to stay and serve the public.

Would you have great problems, if indeed cigarettes remain legal, as they are and I presume they will remain, that pharmacies would be allowed to retail them as the store across the street does, or is this just political correctness?

**Ms Kovak:** I think I have less concern, to be honest, about pharmacies selling cigarettes than I have about the glamorous packaging and the way cigarettes are presented. Because I lived in a small community, I also understand someone who will drive miles to buy a pack of cigarettes. So I realize that.

However, someone at a meeting recently said that cigarettes are the only legal substance which, when used as recommended by the manufacturer, can kill you. I think that's a powerful argument.

**Mr Villeneuve:** That's a most powerful argument, and certainly education is the best weapon. But I have a problem with limiting the sale in pharmacies and in other areas of a legal product. If they make it illegal, then it's fine. But I think it's simply political correctness and I think many of the major chains will find a way around it.

**Ms Kovak:** I understand that.

**The Chair:** Please go ahead with your response, and then we're going to have to move on.

**Ms Kovak:** I understand your problem with that. I initially had a problem with the idea of freedoms, that someone should have the freedom to do what he wished. However, and you probably have heard this earlier in your hearings, to combat that, one can say there is no freedom in the cancer ward, and that's a powerful argument too.

**Mr Villeneuve:** The use of cigarettes, I have a problem with; I want to see them restricted to those areas. But the sale is my area of concern.

**The Chair:** Ms Kovak, thanks for your presentation.  
1020

FREDERICK KING

**Mr Frederick King:** Good morning. My name is Frederick King and I'm a licensed Ontario pharmacist of Ultra-Mart Pharmacy, Oakville's family pharmacy. I thank you for the opportunity to express my views regarding the proposed Bill 119. The views that I will express are purely my own. I represent only myself and my fellow employees, although the views I put forward represent a similar situation for every pharmacy in Ontario which operates under the same venue as my pharmacy.

My pharmacy practice is set up inside a large megastore of over 40,000 square feet. Basically, the setup involves a large grocery store in the middle of the floor space surrounded all around the perimeter by individual mini-store franchises. One landlord owns the entire building, with the individual stores all paying rent per square foot towards the gross rent.

This is not a traditional mall setting with each store contained within its own four walls, but rather each store has a territory of its own beneath the single roof of this 40,000-square-foot room. If you will, the walls are invisible. There is the grocery store, a flower shop, a

delicatessen shop, a fresh fish market, a bakery, a butcher shop, a wine shop, a proposed coffee-doughnut shop, my pharmacy and a tobacco, lottery, photo-finishing shop. Therein lies my problem.

Although I neither sell nor, for that matter, condone tobacco product sales, Bill 119 as it presently is worded will force either my pharmacy or the tobacco shop to vacate the premises. Paragraphs 4(2)8 and 9 of Bill 119 preclude the sale of tobacco products in a pharmacy or any area that is directly accessible from a pharmacy.

My pharmacy and the tobacco shop are at opposite ends of the building, are not visible to each other, and certainly in no way does my pharmacy even remotely appear to promote or send the message that tobacco product consumption is acceptable behaviour. We can't even get around this restriction by walling off either the pharmacy or the tobacco shop within this location, as this has been deemed unacceptable as the present bill stands.

Having talked to the other merchants at my location, I can tell you that although they agree that cigarette consumption is hazardous to one's health, they also feel it's a product which all individuals of legal age in a free society may legally consume if they so desire. The other merchants also strongly believe that tobacco sales bring in extra traffic to the location, and we all know that traffic is the lifeblood of any retail operation.

If the landlord decides that tobacco sales and the traffic it brings in is more valuable to the overall operation, then I'm afraid my pharmacy, my livelihood, will be banished from our megastore operation. I and my eight employees will be effectively put out of a job, and we don't have anything to do with tobacco sales or promotion of tobacco whatsoever. We will be innocent victims of a well-meaning but slightly flawed Bill 119.

In fact every pharmacy that exists in this type of situation, that is, every Zellers, every K mart, every Woolco, every A&P, every Safeway, every Miracle mart, every Loblaws, every Knob Hill, every Zehrs, every Eaton's etc that has a pharmacy operation within its megastore setting—and we heard earlier that there are about 150 of these types of pharmacies throughout Ontario—could all be permanently closed, tossing hundreds of pharmacy clerks, technicians, stocking personnel and of course pharmacists out of a job, all because tobacco is located under the same roof as a pharmacy, even though in every case the pharmacy department has absolutely nothing to do with the sale or promotion of tobacco products in these locations.

I at this time implore you to enact an amendment to Bill 119 which would allow special status for pharmacy and tobacco shops to coexist under the same roof, only—and I stress only—in the megastore setting and only as long as the pharmacy, the pharmacist or any pharmacy employee has no physical or financial connection to the tobacco shop and neither shop is visible to the other.

Furthermore, a megastore should be defined in the regulations as a location of, say, 30,000 square feet or more. This would effectively limit this amendment to the type of situation intended, with no room for cheating on the law by certain other vocal advocates of tobacco product sales in pharmacies.



Let me again reiterate that I agree that tobacco is a dangerous and addictive product which should be regulated and controlled. But as the present Bill 119 stands, it could very well force many innocent and compliant pharmacies out of business simply because of the location of their practice, not because of their desire or need to sell tobacco products.

One final comment I have concerns the direction of Bill 119. I am hoping that this is only step one in a multistep process to ultimately ban the sale of tobacco products in all retail establishments. I'm hoping the government is aiming for a single outlet for tobacco, such as an LCBO outlet, but since the government has not yet enunciated any plans or desires to expand upon the bill, I can fully appreciate other pharmacists' fears of being singled out as the only retailer banned from selling tobacco products.

If the government could only assure us the retail ban of tobacco sales will be gradually expanded to encompass all outlets to eventually dry up the sources of tobacco supply at the retail level, except for the government stores of course, then I feel all pharmacists could more readily and comfortably cooperate with the government's desire to make step one in the process the banning of tobacco products in pharmacies.

Thanks for your attention, and please give serious consideration to the amendment I have requested.

**The Chair:** Thank you very much. I want to clarify and make sure we understand. The operation that you have is not like, for the sake of argument, a Loblaw's or a Zellers, where you are part of that operation. You're in an area that is open and has a series of different merchants who are selling a variety of goods, but they're all independently owned. Am I right?

**Mr King:** That's correct. Actually, a Zellers or a Loblaw's would still fall under the same category because the pharmacy is under one roof, there are no individual walls, and part of the bill says if you can get the tobacco from the pharmacy, then one or the other has to go.

**The Chair:** But in your case everybody's totally independent, one from the other, which is different from some of the other situations we've had where one company owns everything there.

**Mr King:** Basically, yes.

**The Chair:** I just wanted to be clear on your situation. We'll start questions with Mr McGuinty.

**Mr McGuinty:** Just to pursue that, I'm not clear. If I walk into this Ultra-Mart store, this actually consists of a number of different booths, so to speak, owned by different owners?

**Mr King:** Yes.

**Mr McGuinty:** That's the way it works?

**Mr King:** Yes.

**Mr McGuinty:** So do you generate any returns as a result of cigarette sales that take place somewhere else?

**Mr King:** Absolutely nothing. I have nothing to do with cigarette sales whatsoever.

**Mr McGuinty:** Do you have any say over whether cigarettes can be sold elsewhere within Ultra-Mart?

**Mr King:** Not at all, no. I have absolutely nothing to do with cigarettes. I have no desire to have any dealings with cigarettes. But as the bill presently stands, since cigarettes are sold under the same roof as the pharmacy, one or the other has to go, even though we have no connection to each other.

**Mr McGuinty:** How many people work in your pharmacy?

**Mr King:** Eight people.

**Mr McGuinty:** How many pharmacists?

**Mr King:** Myself and a second pharmacist, so there are two pharmacists, two technicians and four clerks, cashiers.

**Mr McGuinty:** Those technicians, have they received special training?

**Mr King:** Absolutely.

**Mr McGuinty:** Through a college program?

**Mr King:** Either through a college program or else they've been trained on the job.

**Mr McGuinty:** What are your chances of getting a job elsewhere?

**Mr King:** I like to look at the paper every day, and there just aren't too many pharmacist jobs in the paper any more. I might get lucky and find a job somewhere else. I have credentials and I have experience. But we're talking about 150 pharmacies here, and if you're talking two pharmacists for a location, that's 300 pharmacists who are suddenly going to be looking for work if tobacco is deemed to be more valuable to the operation than the pharmacy. In a lot of these cases, like some of the Zellers and some of the K marts, the pharmacies are not making very much money, so obviously the landlord could very well decide, "Let's get rid of the pharmacy and keep the cigarettes."

**Mr McGuinty:** What are you going to do if you don't get another job?

**Mr King:** I guess I'll be down at the unemployment office.

**Mr McGuinty:** Do you have any dependants?

**Mr King:** Oh, yes.

**Mr McGuinty:** Who have you got?

**Mr King:** I have my wife and I have a son.

**Mrs Dianne Cunningham (London North):** You didn't think you'd get asked questions like that, did you, coming down here to give us some good advice?

Of all of the witnesses who have come before the committee, I think we haven't had anybody who hasn't been in support of the legislation. What we're looking to do here is to make amendments, as you've suggested, so I'd like to thank you for your assistance. I'm wondering if your brief that you made today is in writing and we'll get a copy of it, or at least the amendment. We have to have a copy of the amendment.

**Mr King:** It's handwritten, but sure.

**Mrs Cunningham:** That's all right, as long as we have something that we can put on the record.

**The Chair:** Mrs Cunningham, you should know it is part of our record now, because he has read it.

**Mrs Cunningham:** In the Hansard.

**The Chair:** Yes, so we at least have that.

**Mrs Cunningham:** All right. It takes a long time for us to get the Hansard, though, and if we're looking at clause-by-clause—

**The Chair:** We will be getting the recommendations, though, more quickly.

1030

**Mrs Cunningham:** Okay. I'll count on the research people to give us the intent, anyway.

We've actually been having some very interesting presentations, and some have gone so far as to say that any retailer that sells tobacco has to be individually licensed so that we can have some jurisdiction over revoking a licence as the fine, as opposed to money, and others have gone so far as to suggest that tobacco is so lethal that it should be sold only in LCBO stores, along with alcohol. Would you like to comment on either of those alternatives?

**Mr King:** As I said at the end of my presentation, I'm a little bit confused as to the direction the government is taking. Is this just a one-shot deal where tobacco is taken from pharmacies and everybody else continues to sell it unimpeded for ever? I think that's why a lot of pharmacists are upset about losing tobacco, because they figure they're being discriminated against, singled out as the only retailer that's going to lose this product.

If the government could just tell us that this is a multistep process—you know, maybe every six months they're going to take tobacco away from another retailer until by the year 2000 there are no retail establishments selling tobacco, and in the meantime they're going to be phasing in the government type of store to sell and control the sale of tobacco—then I think we could all happily accept what this bill is gearing towards.

But as it stands now it's just like a one-shot—cut tobacco off from pharmacies and everybody else keeps on selling it. Quite frankly, I can agree with all the other pharmacists that that's not going to stop smoking. It's just going to shift the sale of it from one location to another.

Now, who's going to sell it? Sometimes I have hesitations, really, about the government getting control of a product because the government tends to get hung up a lot of times with red tape. Sometimes they don't get the best value for their dollar when they run operations.

**Mrs Cunningham:** I certainly share your view on that or I wouldn't have taken this job, I'll tell you that. It's the one reason I did it, and I haven't been very successful in reducing the bureaucracy in opposition. Maybe I'll get a chance in government. But don't get us on that one.

I think the real issue is that we're supposed to be looking at the sale of tobacco here, especially to young people, and if you want to get tough about it, one of the suggestions was to license the retailers; the other was to take it right out of retail stores and put it somewhere else, and that's really the only reason. But I appreciate your comments in that regard.

**Mr King:** I think the ideal situation would be into a

single outlet, which is obviously going to be very diligent about checking for ID. But you just can't one day be selling tobacco everywhere and the next day have it only in one location. It has to be a phased-in process. You have to give these retailers that are presently selling it an opportunity to phase out of the product, and if it's the government that's going to take over the sale of it, it's got to have a phase-in period to get its operations set up efficiently.

**Mrs Cunningham:** You make very good sense.

**Mrs Karen Haslam (Perth):** First of all, I've got to apologize. I'm just so tired right now I'm not understanding this, and I want to follow through with Mr McGuinty's questions. Are you hired by this group that you are there with, or is it your store that you operate? Because when he started asking about where you would go and what you would do and things like that, this Miracle Ultra-Mart Pharmacy—are you the owner of Miracle Ultra-Mart Pharmacy?

**Mr King:** I do have some interest in it, yes, but I'm not the whole owner.

**Mrs Haslam:** Of just the pharmacy part?

**Mr King:** Right.

**Mrs Haslam:** It is an individually owned entity within a larger setting. Is that correct?

**Mr King:** That's correct.

**Mrs Haslam:** And there are other entities within this that are separately owned.

**Mr King:** Separately owned, yes. That's correct.

**Mrs Haslam:** I see. So you own part of this pharmacy. When we talk about the possibility of the landlord, we're talking about the landlord, meaning this conglomerate that owns this—

**Mr King:** The owner of the building, yes.

**Mrs Haslam:** So it's a building.

**Mr King:** A building. It's not a mall with little stores in it; it's one big room, so to speak, with several little stores set up inside it.

**Mrs Haslam:** It's almost like a flea market.

**Mr King:** A little more sophisticated.

**Mrs Haslam:** What I mean is, it's like a flea market because they have individual booths and each booth looks after itself. They pay to be there in this building.

**Mr King:** That's correct.

**Mrs Haslam:** This is a situation where the landlord has the building. Do you pay him rent?

**Mr King:** That's right.

**Mrs Haslam:** On your area that you have in the building, okay. You would have an opportunity, then, as an owner of this building, to choose to go to another location, because you own the business.

**Mr King:** In theory, yes, but in reality, no, because first I'd have to go out and find myself another location, another store, and my business is not necessarily going to follow me there. Plus, the big thing about having this location is that there is all this built-in traffic. If you go to a little corner store and set up your pharmacy, the traffic's not there.



**Mrs Haslam:** Your business would follow you because you're in the business of pharmacy.

**Mr King:** Not necessarily. Convenience is what people are looking for nowadays.

**Mrs Haslam:** But you're a pharmacist, and you have a monopoly on prescriptions. So if you're not there, you must have that business follow you because you're the only one who gives the prescriptions.

**Mr King:** Not necessarily. In a rural setting that could be true because there's nowhere else to go, but in an urban setting there is basically a pharmacy on every corner, and convenience is what rules. Unfortunately, loyalties aren't what they used to be, and people are going to go where it's convenient. That's the bottom line, convenience nowadays.

**Mrs Haslam:** I do appreciate your idea about the phased-in and phased-out approach. That has not come before the committee. When you talk about the government not knowing where they're going, that's what these consultations are about. We've had consultations about it before—

**Mrs Cunningham:** Karen, do you know what you just said?

**Mrs Haslam:** I didn't interrupt you, Dianne, thank you very much.

#### *Interjections.*

**Mrs Haslam:** We had consultations beforehand where we had people come in and talk to us about what should be in the basis of the legislation. The legislation was put out. Have you looked at the legislation?

**Mr King:** Yes, I have.

**Mrs Haslam:** Okay. I want to be very clear on this: We did not single out pharmacies. What we said was "health facilities." You are one health facility. When you came before another committee saying, "We are health practitioners and wish to be governed by the RHPA," you came before us as health practitioners. "We are a health entity." What this legislation does is say that tobacco is not sold in health facilities, of which you are one.

I know you feel that pharmacies have been singled out, and that's not true. What we're saying is that there are some businesses that sell tobacco and they hire a pharmacist, and that is a difficulty for that person who has a business selling tobacco but it's more difficult for the pharmacist, because under the code of ethics, you are not to promote the selling or the giving of drugs that hurt people.

**Mr King:** I have no problem whatsoever with pharmacies not selling tobacco. I'm just trying to help appease the situation, maybe get the other pharmacists who want to keep selling tobacco to understand that everybody is going to lose it sooner or later. But the government hasn't said that yet, so as a result, a lot of pharmacists who are presently selling tobacco feel that they are being singled out, discriminated against, and everybody else is going to keep selling tobacco for ever.

**Mrs Haslam:** I understand that.

**Mr King:** I just wish the government could say that this is a multistep process and six months to a year from

now tobacco is going to be taken out of department stores, and then in another six months to a year they're going to take it out of gas bars, until the final step kicks in, in the year 2000 or whenever, when nobody is selling tobacco except a certain regulated outlet.

**Mrs Haslam:** This is the first time that's come forward, and I think we all appreciate it, because it's the first time anyone has broached the subject in this way.

**The Chair:** Mr King, thank you. I think you've raised a number of issues from a different perspective that obviously have taken the interest of the committee, and we appreciate it.

DONNA RITCH

**The Chair:** I call on the Tobacco Use Prevention Coalition of Durham Region, Ms Donna Ritch.

#### *Interjections.*

**The Chair:** Order, please. I note committee members have been on the road, so they're a little tired.

**Ms Donna Ritch:** Everybody's a little excited. I've been watching your hearings on TV. At 6 o'clock every night at our house we are supposed to be eating dinner and we're all watching you.

**The Chair:** I don't know whether that's frightening or pleasing.

Okay now, committee members, if everybody just kind of does a stretch and—

**Ms Ritch:** Yes, good idea. Have a little health break.

**The Chair:** Ms Ritch, we have a copy of your written submission. Please go ahead.

1040

**Ms Ritch:** Thanks very much. Good morning, everybody. I'm excited to be here. I know that you're not excited, but I am. Actually, I'm here today wearing two invisible hats. I'm here representing the Canadian Cancer Society volunteers as well as the Tobacco Use Prevention Coalition of Durham Region. Now, that is quite a handle, isn't it?

Before I begin my submission, may I say, and I do mean this sincerely, how gratifying it is to see members from different political parties working together as a team. Like our coalition, you are all working towards a common purpose: the passage of a sound Bill 119.

You have before you our formal submission, which substantiates many of the opinions expressed to the committee thus far. I'd like to share with you a few personal stories to reflect the thoughts in the submission before you.

Like many of the people you heard from, I too was the child of smoking parents. I began smoking at age 11. In those days, if you can believe it, I didn't like the fact that I looked younger than my age. Today I would love it. I could just think that a cigarette would add to this more mature image.

I smoked off and on until I met my husband, who is a non-smoker. It's interesting to note that a lot of people who care about those who smoke try everything, including the worst possible guilt trips, to get them to quit. Fortunately, my husband did not do that, but I knew that it was very distasteful to him and he was not impressed

by it. I was impressed by him, so I quit. At that time I quit cold turkey.

My parents never did quit smoking. While my father had a known heart condition, smoking no doubt contributed to his early death at age 60. My mother required bypass surgery due to failing circulation related directly to smoking. While she did survive that surgery, she went on to require further surgery. The day before she went for that last surgery, I can remember my sister telling me that she was pleading for just one last cigarette. My mother's overall health was weakened by a lifetime addiction to a deadly product. She did not survive that surgery. She was 60 years old.

My children tell me that I lived in the olden days. I don't know; if any of you have children, you might relate to that kind of comment. In those days, interestingly enough, teens really did care what their parents thought and they cared about getting caught smoking. That was even more interesting, considering both my parents smoked, but I did care about that.

My best friend and I, though, developed this really neat strategy; we thought this was terribly unique. This committee can probably tell me it has heard this before. At her house we lit one cigarette and we said it was mine. We thought that at my house we would say it was hers. That worked really well until our parents met each other and the truth came out.

Interestingly enough, both sets of our parents smoked. My friend Christine's mother was successful in quitting years later. The week that I joined the Canadian Cancer Society, I'll never forget the tearful call I had from Christine telling me of her father's diagnosis of lung cancer. Having had surgery, he is doing very well five years later and is probably an unusual statistic, because that's not usually the case. Christine still smokes, despite a passionate desire to quit.

My husband and I are happy that our three teens are at present smoke-free. Coming from a smoke-free home may be just one contributing factor that keeps them away from cigarettes. Many others in my family have smoked long before it was legal to do so. I had been a sad observer of their health problems related to smoking, as well as the many attempts to quit. It is truly a powerful and painful addiction.

How then can we spare our young people from this addiction? I have a lot of compassion for those people who are addicted, and it's not about being cruel and mean. It's about looking at ways to prevent other people from going through this kind of suffering. I believe Bill 119 is a really good start. It has so many components that those of us who care about the concerns of tobacco look for.

To be specific, those concerned about tobacco—keeping in mind that two thirds of us are non-smokers; we couldn't have said that 15 years ago; we have come a long way—want to live in a society that promotes health, and that includes government and health-related organizations. I'm interested in some of the comments I've been hearing this morning, but it wasn't too many years ago that you could find cigarettes sold in hospitals. We know that cigarettes are not compatible with health

and do not belong in hospitals. Is the same not true for pharmacies? How can we look at that any differently?

About four years ago we moved from Scarborough to Whitby, Ontario. I was canvassing the neighbourhood, checking out the local pharmacies and being basically nosy. I went into one of the pharmacies and I found the pharmacist to be very, very pleasant, but I did ask him, "How is it that you sell tobacco products?"

I think he was afraid the next day I was going to go out with banners picketing his pharmacy, which I didn't do. I just wanted to know, "How can you do this?" He said: "I don't believe in smoking. My family is smoke-free. None of us smoke. But I choose to sell it in my pharmacy, and unless I'm legislated not to do so, I will continue to do so." At that point I decided to find another pharmacy.

The Canadian Cancer Society and the Tobacco Use Prevention Coalition of Durham Region applaud the inclusion of the tobacco ban on pharmacies in this bill.

As this committee has heard, there are all kinds of little special situations, and certainly we need to work through them. I don't think there's any one person you've heard from who has all the answers to every problem. It's something that we need to work through and keep talking to each other about.

What else do people concerned about environmental tobacco smoke look for? We want places to eat, shop and play that are smoke-free. You were talking earlier about stores and retail outlets that are smoke-free. There's a Tim Horton in Pickering, Ontario, and it's doing wonderfully well with a smoke-free environment. We also have a terrific place in Whitby called Wheelies. It's a roller skating rink. I am not brave enough to try it, but I do let my kids go there. It's smoke-free and, interestingly enough, it has not suffered any loss of revenue by doing that.

By legislating public places to be smoke-free, the bill conforms to the majority of smokers who want to be protected from environmental tobacco smoke. You've heard before that there is no safe level of tobacco smoke. Interestingly enough, you keep talking about the legal issue. We know, and you've probably heard this—I haven't heard you every day, but I'm sure someone else has said it—that if it was invented today, tobacco wouldn't be allowed. We know that.

We know it would have tremendous ramifications if we stopped it completely and it would be an incredibly cruel thing to do to people who are so terribly addicted to the product. We'd have mass hysteria. That's not the answer. However, in public places there is no safe level of tobacco smoke. The only way to get around it is separately ventilated areas. The same is true of course of workplaces.

The emphasis is on helping our young people remain smoke-free. It is clear from listening to the young people that I've heard present to your committee and from other organizations that not one strategy alone will work. It will take a multidimensional approach. Any possible health consequences from smoking are believed to occur only to old people, a group to which young people will



never belong, or so they think. Smoking is attractive to young people and we can help make it less so. Restricting smoking to those 19 and over with credible identification is a good start.

You've also heard that the Canadian Cancer Society did a study on plain packaging and you've heard the results of that which support plain packaging as being an uncool product. I don't think it's time to study it; I think it's time to implement it. We know as human beings we are all influenced by image, and youth are no different.

Visiting Oshawa last summer, if you came to see us, you would have noticed the huge banners advertising Players Ltd auto racing. Do we not think our children will link the image of smoking in a sporting event? Let's ban tobacco industry sponsorship.

Added to this multidimensional approach, we need to recognize that youth are influenced by role models. Positive, age-appropriate role models could deter youth from smoking.

#### 1050

This committee has also heard recommendations for controlling accessibility to tobacco. Vending machines cannot adequately be supervised in all areas to ensure young people will not have access to them. Maybe this committee can find a way to help phase that out. We're not talking about changes due tomorrow. We're not talking about not helping people in a compassionate way. We're talking about a plan.

It is clear, as I've stated, that not one strategy alone will work but a multitude of strategies. We, health organizations and the government, need to work on this challenge together to find the answers. We need to keep talking to each other.

In summary, what do Canadians need? We need a government that promotes health, we need communities where the air is clear and we need to help our young people in every conceivable way to remain smoke-free. Bill 119 can help to accomplish this.

My heartfelt congratulations for this excellent piece of legislation. The Durham region tobacco coalition and the Canadian Cancer Society are anticipating a strong, decisive Bill 119. This is your opportunity to deliver it to them. Thank you very much.

**Mr Villeneuve:** Ms Ritch, thank you for a very good presentation. We've also received correspondence totally supporting your stance from Dr Robert Kyle, who is your medical officer of health in Durham region, and certainly we support him.

My problem is that the pharmacists at the back of the store do not dispense cigarettes, either one by one or packages. It's at the front end of the store. I come from an area, as you may have heard earlier, that is very much rebelling, to the point where cigarettes, tobacco products and other products are driving a very thriving underground economy. My concern is that we still have a legal product here in tobacco, like it or not.

**Ms Ritch:** Regrettably so.

**Mr Villeneuve:** I agree with you that if it were to come on the market today—it causes cancer. You light it up, you put it in your mouth and yuck, it's not good.

However, people are addicted, as you have so ably pointed out.

My problem with this legislation is, your recommendations I think are great except the legislation we have probably only covers about half of those, and then we come into an area of regulations. I agree that a minor or a person under 19 should not have access to cigarettes, but in the underground economy there's only one thing that speaks, and it speaks loudly, and that is dollars. In the high schools that I represent, we have a very, very extensive network of onsite deliveries into the school, out of the trunks of cars, and if you've got \$22, whether you're 10, 12, 14 or 19, you're going to get your carton of cigarettes.

**Ms Ritch:** They don't care. That's right.

**Mr Villeneuve:** I am concerned with overregulating in this area. A pharmacist in rural Ontario will not be allowed to sell cigarettes, whereas someone across the street, next door, whatever, who is not a pharmacist—the pharmacist himself may own the business, but he's not dispensing cigarettes. They're simply there. Could you maybe express your comments?

**Ms Ritch:** I hear what you're saying. My question would be, how could a pharmacist be made to somehow be separate and not in support of tobacco product when it's in the same room, no matter how large that room is? Is there a way to do that? It's almost like a question to your question. If a pharmacist could be shown to be against selling tobacco and for smoking cessation, then there would be no problem, if you could find a way of doing that.

**Mr Villeneuve:** The licensed person may well be the lady at the cash register and not the pharmacist. The pharmacist may well be totally against the use of tobacco products, but we are discriminating against him as a business person when we do this. The licensing is an excellent idea I believe, and the penalty for breaking the law, selling to minors, would be the revoking of the licence.

**Ms Ritch:** Yes. So you're not worried about banning tobacco sales in pharmacies that are completely separate? That part does not concern you. Is that right?

**Mr Villeneuve:** To me, the front end of the store and the prescription end of the store are totally different. I've never viewed the back end of the store as being even tied to the front end of the store.

**The Chair:** Sorry. We've got questions here and we're going to have to keep moving.

**Ms Ritch:** I'll talk to you later.

**Mr Jim Wiseman (Durham West):** Thank you for coming to the committee from my neck of the woods.

**Ms Ritch:** My pleasure, Mr Wiseman.

**Mr Wiseman:** I have a decidedly different view of the world than Mr McLean.

**Mrs Haslam:** Than Mr Villeneuve.

**Mr Wiseman:** Oh, Villeneuve, sorry.

**Mr Villeneuve:** You're in the right party.

**Mr Wiseman:** You're all so nondescript.

**Ms Haslam:** They sit beside each other. The Tories all look alike.

**Mr Wiseman:** Yes, they all look alike.

The reason I have a different view of the world is that this legislation is primarily designed to drive home a message to young people. The message is: "Don't smoke. It's not healthy. You may think it's cool right now but you are going to regret it later. So the best view is, don't start." We have heard time and again where young people have come before the committee and said that it's cool, that it's in.

**Ms Ritch:** Yes, absolutely.

**Mr Wiseman:** And you had this detachment of the medical profession at one point in our history saying, "Hey, smoke this one, because this is really great."

**Ms Ritch:** You'll be thin and beautiful.

**Mr Wiseman:** Thin, beautiful and dead soon, and going out in a very bad way. This is a terrible mixed message. The pharmacists I believe have got to decide what they are. They are either retailers and vendors of an addictive product in cigarettes or, as they want to claim themselves, they are health practitioners. They can't slice it both ways.

**Ms Ritch:** I'm in total agreement with what you're saying.

**Mr Wiseman:** We heard from a 12-year-old boy yesterday in Thunder Bay who purchased eight packages of cigarettes and no one asked him for his identity. He said, "Hey, look at me, do I look 19?" Obviously, he wasn't. He had purchased them and some of them he had purchased from pharmacists. One was from a Shoppers Drug Mart. All of them have claimed that they do a wonderful job at preventing the sale of cigarettes to young people. Have you run any kind of comparative studies in Durham to find out how many pharmacists or how many vendors actually say, "I'm not selling to you because you're underage"?

**Ms Ritch:** That's a great idea, Jim. That's a really good idea. To date, I don't know of any. I have just looked at my own little town of Whitby. Of course we have two or three Shoppers Drug Marts in Whitby alone, several Guardians, and then we have Whitby Community Pharmacy, which does not sell tobacco. You also heard from Brooklin, which is just north of us.

**Ms Haslam:** Who made up their profits over a stretch of time.

**Ms Ritch:** Yes. I was very impressed with their submission.

**Mr Wiseman:** They didn't lay anybody off.

**The Chair:** Mr Wiseman, I'm sorry, we're going to have to move along.

**Mr Wiseman:** Thank you for your presentation.

**Ms Ritch:** My pleasure.

**Ms Yvonne O'Neill (Ottawa-Rideau):** I'd like you, if you could, to say a little bit more about the annual evaluation. I really don't think Bill 119 is going to do all that people think it will do. It requires an extreme amount of self-monitoring in every little hairdresser, in every little laundromat in this province. We all know that

they're very short-staffed in law enforcement and inspection groups, and I don't think that's going to change.

Could you just say a little bit more about this annual assessment? You're one of about two people in our entire hearings who have mentioned it. I think it's very important. I think the Ontario population has a right to know how this bill is progressing, because there has been a lot of approval of the bill, but enforcement is going to be a very big part of its success.

**Ms Ritch:** Yes. You're absolutely right. It's so interesting that we implement things without looking at the long term and how well it worked. When we think back to the approach that we took to smoking 15 years ago, when it did become socially unacceptable, it has had an enormous impact on society when we know that two thirds of Canadians used to smoke. Now two thirds do not. So some things are very obvious.

1100

What we would have to do is sit down, and it would have to be with someone who has background in evaluation. Certainly, a lot of the leading universities are very, very good, and certainly the cancer society has used them in the past—the University of Waterloo, the University of Toronto—who can help us set out some kind of, number one, criteria of what we are looking for, what we are trying to measure, who will help us measure that and who should be involved.

You are absolutely right, it's not something you're going to decide today, it's something that would have to require several people coming together and a long-term plan. Probably you're looking at a five-year plan.

**Ms O'Neill:** Thank you so much for that suggestion.

**Ms Ritch:** My pleasure.

**The Chair:** Parliamentary assistant, you have one comment?

**Mr Larry O'Connor (Durham-York):** I'd like to make the comment that up in the north part of Durham region, we've got quite a bit of work going on up there. The Uxbridge community is really involved: two pharmacies, one smoke-free, one not, which will be going smoke-free. The work in the community is really wonderful. We know we can't do it alone, we know you can't do it alone and we're working with you. There was nothing more warming for me, being the parliamentary assistant working directly with the minister on this legislation, than to drive into Uxbridge and see that banner across the main street saying, "Let's be smoke-free."

**Ms Ritch:** Fantastic.

**Mr O'Connor:** There's a lot of good work going on in Durham. I just wanted to say that.

**Ms Ritch:** That's great. Good stuff. Thanks for smiling so much, Larry.

**The Chair:** Durham must just be full of wonderful folks.

**Ms Ritch:** Oh, yes, you'll have to come and see us some time.

**The Chair:** Thank you very much for coming before the committee this morning.



**Ms Ritch:** Thank you. It was entirely my pleasure. Good luck with all your work and I hope you all get some rest.

LESLEY LAVACK

**The Chair:** I call on Ms Lesley Lavack, the coordinator of professional practice for the faculty of pharmacy at the University of Toronto. Welcome.

**Ms Lesley Lavack:** Thank you, first of all, for giving me an opportunity to appear before you today. I'd like to congratulate the government on its initiative in introducing Bill 119, the Tobacco Control Act.

I've been a pharmacist in Ontario for almost 26 years, although sometimes it feels like 126, and I've seen significant changes in pharmacy practice over that time. I've worked in community practice, in both retail and medical centre settings, in hospital practice as a clinical pharmacist and as the manager of an outpatient pharmacy. Presently I'm the coordinator of professional practice at the faculty of pharmacy, University of Toronto. I have also, over my career, been very fortunate to have worked with pharmacy organizations, government and industry.

Individuals and organizations appearing before this committee have made no attempt to dispute the well-documented health hazards associated with tobacco, both through direct consumption and through indirect effects. Debate has occurred, however, about some of the components of the bill. My remarks today will focus primarily on issues related to the sale of tobacco in pharmacies and the role of the pharmacist. In addition, I will comment on issues related to the general sale of tobacco.

As a legislative body, you're working hard to manage programs and to meet increasing constituent demands with finite and often shrinking resources. You must assure that tax dollars are spent wisely and that taxpayers get good value for their investment. Of particular interest to me is the investment that governments make through the Ministry of Colleges and Universities in the education of pharmacists.

Pharmacists are educated at significant cost, both to themselves and to taxpayers. Pharmacy education at the University of Toronto is challenging. Our graduates are educated to be health professionals. This includes four years of post-secondary education, 32 weeks of student training, 16 weeks of internship, pharmacy examining board examinations, all as requirements before students are eligible or considered for licensure in Ontario.

It is essential that pharmacists be utilized appropriately. This means a focus on professional activities. If this does not occur, I suggest that the citizens of this province are not receiving appropriate value from this well-educated health profession.

Shortly before I graduated in 1968, the dean of pharmacy at that time, Dean Norman Hughes, made an address to the Ontario College of Pharmacists. In that address he expressed concern about the dichotomous nature of community pharmacy. He suggested at that time that the emphasis on the commercial rather than the professional aspects of community pharmacy was having many damaging effects.

He said, "We have all known, and some of us have said it many times, that the only possible future for pharmacy as a health profession lay in concentrating on and developing and expanding and improving our professional services and competence." In the same address, he suggested that it was the 11th hour for pharmacy.

With the debate that has occurred before this committee about the professional versus the commercial side of pharmacy, many of you must be wondering if the pharmacy clock stopped ticking over 25 years ago. It didn't, but some issues continue to plague our profession and tobacco is one of them.

Pharmacy, as I know it and as I've practised it, has always been a health profession. Pharmacists are educated as health professionals. Pharmacies, it follows, are health facilities, since they must be owned and/or operated by pharmacists. From beginnings in apothecary shops, where mysterious potions and mixtures were compounded, pharmacy evolved to being a distribution centre for manufactured pharmaceuticals.

Pharmacy has continued to evolve as patients' needs change. Today, in the changing face of health care, pharmacy is meeting different needs. Patients need information about their medications in order to use them safely and effectively and to minimize problems associated with drug use. Pharmacists must take responsibility for identifying, preventing and solving drug-related problems in individual patients. In addition, and in line with government principles, all health professionals must find ways to promote health and prevent disease.

The societal and economic impact of preventable morbidity and mortality must be addressed. Tobacco is the number one cause of preventable death in Ontario. The impact of tobacco-related morbidity is huge. It is absolutely incompatible for pharmacies as health facilities to sell tobacco. I also believe that it's a conflict of interest for pharmacists to profit both from the sale of tobacco at one end of a pharmacy and the sale of medications to treat the effects of tobacco consumption at the other.

Committee members are well aware that this ban also reflects our own licensing body's request for legislation. This committee, I believe, has a responsibility to assure that pharmacy, as a self-regulating profession, is given the legislative authority requested by its college.

Pharmacists have appeared before this committee to argue that on economic grounds pharmacies must be permitted to maintain tobacco sales. The committee should also be aware that, in fairness, some pharmacies that continue to sell tobacco have made efforts to enhance their pharmacy services through patient counselling, improved medication monitoring and other professional services.

While I applaud these efforts, the argument that revenue from tobacco sales is necessary to support these activities is simply not convincing. Although I am sensitive to the potential economic impact that the removal of tobacco may have on these pharmacies, no one ever said that doing the right thing is going to be easy.

I expect that these pharmacies will find creative means of meeting their bottom line. These means may include developing alternative reimbursement schemes for professional activities, and that may include reimbursement for smoking cessation counselling and monitoring.

A more compelling argument is that the removal of tobacco from pharmacies will not reduce overall tobacco consumption and may in fact lead to easier access to tobacco by youth. This is a real, serious concern. The underlying principles of this legislation relate to reducing tobacco consumption generally and to preventing youth from starting to smoke.

In view of this very serious concern, I recommend that amendments to this legislation be considered. These should include, in my view, controlled sale by licensed vendors, strict enforcement policies and stiff fines for contravention of regulations. These measures are necessary if the overall objectives of this legislation are to be met.

**1110**

I would also like to suggest to the committee that responsibility and accountability for tobacco use must be shared. Pharmacists can meet their professional mandate by removing tobacco from pharmacies and becoming involved in smoking cessation programs. Vendors can be made accountable for compliance with regulations related to the sale. Governments can ensure that the sale of this harmful product is controlled and can continue to provide educational materials, suggest packaging changes and require clear warnings about the dangers of tobacco use.

But what about the individual who, regardless of these measures, chooses to smoke? Surely this individual must share some responsibility for his or her health outcomes. Although I do not have an answer to how this could be accomplished, I do believe that the changing face of health care today means that your constituents, taxpayers of this province, must take reasonable steps to maintain their own health.

In summary, although the problems associated with the sale and use of tobacco are difficult and complex, I am personally confident that the end result will justify these very controversial means. Thank you.

**Ms Carter:** Thank you very much for your presentation. It was very helpful. I work with the Ministry of Citizenship and I have a special interest in seniors and drugs and some of the problems that happen with over-medication and so on. It has come to my attention in that context that—after all, the government is trying to economize on drug benefit plans and other things and there is a growing trend towards medication by mail, I guess, which would circumvent regular pharmacy outlets.

Of course, a big argument on the other side is that the pharmacist is a skilled person and can give advice to a client, can make sure that the medication is correct. Also, in conjunction with the government, there is now an electronic system whereby the history of what medication a patient has had is readily available to the pharmacist and they can therefore make sure that the person is not taking drugs that will produce complex side-effects and so on.

There is, in other words, an emerging picture of the pharmacist as somebody who is not just there to hand out drugs, because that can be done by other means, but who is there as, if you like, another health practitioner who complements the doctor and can make sure that people get the right medication and know how to use it. This, it seems to me, does conflict very much with the whole idea of selling cigarettes, so I just wonder if you could enlarge on that.

**Ms Lavack:** I think you've made some very important points and they're all valid and questions that are occurring daily and something that I am personally very concerned with and I think all of us should be.

The Ontario drug benefit program provides essential services and needed medications to many eligible members of the program. The supply of products—drugs—to patients is something that pharmacists have control over; however, the emerging role and the real need for pharmacists' services really lies in ensuring that those products are used safely and effectively. The simple dispensing of a medication pursuant to a doctor's prescription can be done, as you and I both know, with the use of technology today. We have Baker's cells, bar coding, we can do that very easily.

What the citizens of Ontario need are the cognitive skills of a pharmacist to put medication use into a context of that patient's life, of their needs, and that can only be done if a pharmacist moves away from the counting, pouring, licking and sticking aspects of pharmacy into using what they know for the benefit of the patient.

In terms of the initiatives with the network that you were referring to, I think the use of technology is absolutely essential and I really applaud the beginnings of that technology. We have to use it. We have to use it more effectively.

In terms of how patients purchase products, and you referred to products by mail, prescriptions by mail, that's certainly a concern for some of us, because unfortunately over the years many individuals have felt that when they purchase a prescription from a pharmacy, it simply is a commodity, a thing. A purchase from a pharmacy should in fact include the service of a pharmacist, and I would like to suggest to this committee that that has great value.

**Ms Carter:** And it's not compatible with selling cigarettes.

**Ms Lavack:** Completely incompatible with the sale of tobacco.

**The Chair:** Final question, Mr Villeneuve.

**Mr Villeneuve:** Thank you very much for an excellent presentation. I was quite interested in your mentioning a conflict of interest, and I believe it is to some degree a conflict of interest. Some 25 years ago someone suggested to the College of Pharmacists that indeed conflict should be looked at. What have they done since 1968?

**Ms Lavack:** It's very interesting and I think it's somewhat embarrassing. However, I must admit that we have made progress, and I'd have to come to the college's defence and to the profession's defence. We're not all bad. We're very good people, by and large, and even



for those individuals who continue to sell tobacco, it's a difficult situation for them. There are many, many good people.

In terms of pointing a finger at the college, progress has been made, and defining a pharmacy—what is it?—well, we're trying. Our request to the government, through our licensing body, is in fact an attempt—and I would agree with you, perhaps late, but better late than never—to define and suggest that and in fact ask you to help us define a pharmacy as a health facility.

**Mr Villeneuve:** As soon as governments step in and legislate, loopholes become apparent. Would you, as one representing the college, be ready to take to task some of your colleagues who may be just on the periphery of the law, legal but yet connected with—would the college be prepared to take one of your colleagues to task if indeed they are maybe within the law but yet still in conflict?

**Ms Lavack:** That's sort of like being a little bit pregnant, isn't it?

**Mr Villeneuve:** Those are the realities.

**Ms Lavack:** I'm not sure how you can be within the law but not quite there.

I need to clarify, first of all, before I say anything else, I do not represent the college. The College of Pharmacists is a licensing body for pharmacists in Ontario. I am employed by the University of Toronto and I work as the coordinator of professional practice at the faculty of pharmacy, which is the educational organization and institution for pharmacists, and the only one, I might add, in Ontario.

I am interpreting now as a pharmacist who is licensed by the college. Would the college take action? Certainly. If regulations are codified, then it is a mandate of the college to require pharmacists to comply. Absolutely.

**Mr Villeneuve:** I believe that's the *raison d'être* for the college, and I am one who does not think governments can be the be-all and end-all. They can spend a lot of money and yet not really accomplish what they set out to do.

**Ms Lavack:** That's true.

**Mr Villeneuve:** Whereas you have the power, with your college of professional pharmacists, to make things happen.

**Ms Lavack:** We'll try. You've got me going on a topic that's dear to my heart. Thank you very much for your time.

**The Chair:** Thank you for coming in and for your presentation this morning.

1120

#### COUNCIL FOR A TOBACCO-FREE METRO TORONTO

**The Chair:** I call on the representative from the Council for a Tobacco-Free Metro Toronto, Krista Saleh.

**Ms Krista Saleh:** Thank you, Mr Chair, members of the committee. My name is Krista Saleh. I'm the tobacco issues coordinator at the Lung Association of Metropolitan Toronto and York Region, but I am representing the Council for a Tobacco-Free Metro Toronto, which the Lung Association is a member of.

Just to give you a little bit of background, the Council

for a Tobacco-Free Metro Toronto is a Metro-wide coalition of public health units, non-profit health agencies and other health organizations, such as hospitals, which represent the Metro Toronto area. The council is also a member of the Council for a Tobacco-Free Ontario, which is the provincial organization overseeing the local councils.

One of the projects the council is working on right now is a tobacco-free awards program which awards certificates to organizations that have voluntarily gone smoke-free. We're also in the process of distributing fact sheets which the council developed for health professionals on the areas of tobacco prevention and tobacco cessation, and copies of this fact sheet were handed out to you as well.

The goals of the council are to prevent tobacco use in Metro Toronto and to advocate for a smoke-free society.

The council is excited about Bill 119 and what it can do for tobacco control in Ontario. It's a precedent-setting piece of legislation and we're thanking the government and opposition parties as well for bringing this bill as far as it's already gone and for introducing it. In light of the recent tobacco rollbacks, Bill 119 is even more important than it originally was and it's very important that it becomes a strong bill.

We are supporting Bill 119, especially in the area of the pharmacy ban. We believe that pharmacies, being professional health organizations, should not be selling the number one preventable cause of death, cigarettes, and it's even more contradictory that pharmacies say they promote smoking cessation and sell cigarettes at the same time. That's just a professional mistake, we think.

The council's also in support of tobacco retailer licensing, as well as plain packaging of cigarettes, in helping to make teen access to tobacco more difficult and also in helping the smuggling problem, which is the main issue with the tobacco tax rollbacks.

My focus today, though, other than these issues I just mentioned, is going to be ETS, environmental tobacco smoke, and the workplace.

Bill 119 does not at all address the issue of smoking in the workplace, and it's something that definitely needs to be addressed, because the current legislation, the Smoking in the Workplace Act of 1988, is really ineffective.

Through this legislation, 25% of a workplace is designated as a smoking area, but it makes no requirement that the smoking area is confined to a certain area of the workplace and it makes no requirement that the smoky air be separately ventilated to the outside. Since people spend a majority of time at their work, almost up to 90% of their time, this type of legislation is ineffective and exposes countless numbers of people to environmental tobacco smoke.

You probably know now that ETS is classified by the United States Environmental Protection Agency, or EPA, as a group A carcinogen, which means it falls into the class of cancer-causing agents such as arsenic, asbestos and radioactive substances.

Attached to my written report is a story on Mr Debus, a man who knows what ETS is and what it can do to

him. Two years ago, he was diagnosed with lung cancer, and this lung cancer was caused by smoking. The only thing is, he never did smoke a cigarette in his life; maybe once to try it out, but that's it.

Lung cancer of this type that was seen in Mr Debus is usually seen in smokers, but since he was not a smoker, it was determined that his lung cancer was caused by more than 20 years of breathing in secondhand smoke from his workplace. In the words of Mr Debus, he wants the growing numbers of smokers' rights activists to understand the consequences of their actions and he says, "My days are numbered...they took my life."

Cigarette smoke contains more than 4,700 chemicals. Several of these chemicals are carcinogenic. One of the main damaging substances in cigarettes is tar, and ETS, or environmental tobacco smoke, constituents include essentially all the same carcinogens found in mainstream smoke that smokers ingest. Many of these carcinogens appear in greater amounts in ETS than in mainstream smoke, per unit of tobacco burned, that is, and when we say that pack-a-day smokers usually accumulate at least a half a cup of tar in their lungs over a period of about a year, we can also say that non-smokers exposed to ETS on a consistent basis can expect to accumulate alarming amounts of tar in their lungs as well.

With the Lungs are for Life program that the Lung Association runs in the Metro Toronto-York region area, we actually take out a jar of tar, about a half a cup of tar, with us to show students that this is something that can accumulate in your lungs over a period of a year as a smoker, but also as somebody who is a non-smoker exposed to ETS on a long-term basis or a consistent basis.

At the Lung Association, I myself receive countless numbers of calls from people at work exposed to secondhand smoke. They complain of ETS aggravating their asthma conditions, lost productivity due to headaches and general irritability at the odour of the smoke and other things, and also of management especially being the ones who smoke and therefore the ones who refuse to bring in a safe-smoking policy. Many of these people are not exposed to ETS in their workplace but are concerned family members whose loved ones are actually exposed to ETS. They wonder what can be done and what is being done about this situation.

Therefore, based on what I've just said, current workplace smoking legislation is really not working. Municipal non-smoking bylaws vary in the Metro Toronto-York region area, but put together they basically make up a patchwork quilt. They're all very different. Scarborough, for example, is one area we get a lot of calls from, because the bylaws are different and the amount of smoking that is allowed in workplaces is more than in Toronto, for example.

Therefore, we need a strong piece of provincial legislation that makes workplaces safe for everyone, not just a selection of employees who happen to work in smoke-free environments. Why should one person's life be valued more than another's based on where that person works?

The council recommends that effective amendments be

made to the Smoking in the Workplace Act in time for the fall 1994 session of the Legislature. Ideally, the council would like to see smoking completely banned from all public places as well as workplaces. This recommendation of banning smoking totally is really the only way to truly eliminate the hazards of ETS in the workplace and is much, much easier to enforce.

The decision to ensure that innocent victims like Mr Debus do not continue to suffer rests in your hands. You really have the power to make a real difference for the people of Ontario. I'm just expressing what I see in the community. I thank you for the opportunity to present this information, and if you have any questions, I'll be pleased to answer.

**Mr McGuinty:** Thank you very much for your presentation. I think you make some very good points about the adverse effects of secondhand smoke, and I have to agree that the legislation that's in place now really isn't working, especially in light of the fact it doesn't require separate ventilation. The way I like to put it is to say that you're in a swimming pool and there's a urinating end and a non-urinating end.

**Ms Saleh:** Everyone's going to get it.

**Mr McGuinty:** Sooner or later we all swim in it.

Let's assume, because we've been given no indication that this is so, that the government is not prepared to move further with respect to protecting workers this way.

**Ms Saleh:** Through Bill 119, you mean, or just the bylaw?

**Mr McGuinty:** Through extending the Smoking in the Workplace Act to ban smoking entirely.

**Ms Saleh:** Okay.

**Mr McGuinty:** You're making use of an old psychological—not ploy. What would I call it? You're using positive reinforcement here, which is very commendable. You've announced that you're giving tobacco-free awards in order to reinforce certain kinds of behaviour.

What is it that the government could do for employers to reinforce their either making expenditures to install a separately ventilated area or to eliminate smoking entirely? I'm thinking of a tax break, something along those lines, so we'd put a policy in place which allows employers out there to take advantage of it and encourages them to go forward, and then we wait and see what happens and see how many positive results it would generate. Any ideas on that line?

**Ms Saleh:** Obviously, anything that's going to present an incentive for people to get rid of smoking or create a separately ventilated area is going to be a positive step forward, and I think more people are likely to jump on board that way. But there are also going to be the people who oppose change and are not going to do it on a voluntary basis and are going to need the backing of others or the mandate of legislation before it will really happen.

**1130**

The examples that you were suggesting, though, were good examples. If the government was to encourage people in that way by giving them some sort of monetary



incentive or recognition in some way, that would be terrific, which is what we're trying to do as well.

Of course, we don't have the power to make the legislative changes, but it's something that people, on their own, have actually done in some cases, that some pharmacies, some restaurants, whatever they are, have decided. These are the people who are generally very health conscious or concerned about the people who come into their business or pharmacy. There are also going to be people who are concerned more about economics at the time than they are about the health of the people who come there.

It's the government that needs to set the example and let people know that, although economics is an issue, health is also an issue, especially when you consider the economics of health care costs.

**Mr McGuinty:** From a purely economic perspective, I think you could even make a good argument: the effect that we spend a lot of money in this province to treat our sick people. One third of our budget we dump into health care and a lot of that goes to treat preventable illness and a lot of that is caused by smoking. It seems to me that if we were to give employers—this is just an idea I'm throwing up—some kind of a break in terms of their expenses, the money they send back to the province, we could save that money by not having to treat people who are exposed to these kinds of things. Just an idea.

**Ms Saleh:** Great idea.

**The Chair:** Thank you very much for coming before the committee this morning. We appreciate it.

#### ETOBICOKE BOARD OF HEALTH

**Mr David Bain:** My name is David Bain. I'm a member of the board of health for the city of Etobicoke. My colleagues who have joined me for this presentation are Dr Egbert, medical officer of health for the city of Etobicoke, Mrs McGuire, vice-chair of the board of health and Councillor Marchetti, also a member of the board of health and a city councillor from the city of Etobicoke.

I'd like to start my presentation by indicating that a fairly extensive brief has been provided and there's no practical way to summarize the extent of this brief in 15 minutes. So, like most presenters, I'm going to take this opportunity to try and focus on the key issues.

I'd like to congratulate the government for the work it has done in bringing Bill 119 to second reading and I would like to congratulate the opposition parties for their work in a cooperative effort. Hansard reveals that this has been a non-partisan debate, and I think we can say this is a room full of good people with good intentions. That issue must be borne in mind during this presentation and throughout this entire process.

I watched these hearings with considerable interest. I watched representatives of the Canadian Cancer Society come forward and give you personal stories that moved everyone in the room and everyone who watched that presentation and will watch.

I'm not here today to give you personal accounts, but I will start by telling you tobacco issues have directly affected my life as well. Among other issues, I have a

13-year-old child who is directly affected by this issue and although I won't discuss those matters in detail, I will appeal to all of you to recognize that these matters affect all of us, all of the citizens, and directly. My point is that this is a very prominent issue, not simply because it's controversial, but because we're going to do some very good things with this bill, and I think that needs to be understood.

One of the chief concepts has been boiled down to a debate about pharmacies and whether pharmacists, as health care professionals, should be dispensing a product that when used as prescribed is lethal. I heard presenters before me debating the economics of this issue.

On that point in particular, and I think it's germane to drive to the main points when we have a 15-minute presentation, let me pose to you another consideration: Is it just, from a moral reasoning perspective, to spend \$3 billion a year on health costs that are directly related and indirectly related to tobacco use in our province? We talk about the allocation of scarce resources in a recession, yet we don't hesitate as a province to spend this amount of money on health care that is necessitated by something that is preventable.

These are very important points. I hear about symbolism; in fact, I've heard the expression "just symbolism" numerous times throughout these hearings. Ladies and gentlemen, honourable members, I ask you to really contemplate symbolism.

As I approached Queen's Park today, I saw a very grand building, a building under renovation, but nevertheless a very grand building. I think it's important that we all remain cognizant of what's happening here. The provincial government, within a country that is very big on government by comparison to the United States of America, for example, is undertaking a process that's going to effect an awful lot of good.

There isn't just symbolism in the issue of pharmacists dispensing drugs and contrary messages to our youth. Symbolism is very, very powerful indeed. Let's not try to underestimate symbols: symbols like the Canadian flag to our troops in the former Yugoslavia, symbols like the Canadian flag when members of Canada travel abroad and are treated quite respectfully, and symbols like the Red Cross for help.

Let's talk about trust, because I think that's a very important concept in this presentation as well, the trust that exists between a health care professional and the client or the patient. I think that trust is essential. If anyone in this room was to suffer a medical malady, an illness or an injury, you would not hesitate for a second to provide intimate details of your lifestyle and of your personal health history to health care professionals. The reason you do that without any hesitation at all is because you know this trust is essential to your wellbeing and that these professional health care providers are trying to be efficient and effective and as helpful as they possibly can towards resolving your problem.

All health care professionals are affected by a situation where health care professionals call into question this trust relationship. It's most important that this trust relationship be maintained, and symbols about whether

this health care professional is a retailer or a professional draw that trust into question.

I'd also like to refer to the concepts of responsibility, the responsibility that we have to correct this problem, the responsibility that we have to recognize those who are vulnerable in our society, namely, children, but clearly all people who are addicted to this substance.

The Addiction Research Foundation has told you that it's quite effective and quite appropriate to refer to the addictive qualities of tobacco in relation to drugs such as cocaine and heroin. In fact, our own Addiction Research Foundation here in Ontario surveyed over 1,500 individuals who were addicted to cigarettes as well as either heroin or cocaine and they found it more difficult to give up the addiction to tobacco than to either heroin or cocaine.

Numerous health care professionals and health promotion agencies have presented themselves here in person at your hearings and have provided extensive research to tell you what I suspect most of you already know and that really is not at debate here: We have a substance that is causing tremendous harm, tremendous suffering and premature death to the people in our province and our country, and we have an opportunity to do something about it.

I think it's very important that we recognize the federal government's response to the smuggling issue. Discussing this issue without recognizing the big picture is a little naïve and it is because of recent developments that have clearly increased the access to cigarettes that I suggest to you we must make Bill 119 the very best bill we possibly can.

In her opening remarks to this committee, the Minister of Health made numerous valuable points, one of which was that this specifically was what she hoped she would receive from this committee and all the presenters: valuable information on how to make this bill the best it could be, striving towards reduction targets established by the ministry and striving towards a smoke-free province.

**1140**

Unlike some of the other presenters, I don't call that a Utopian goal. I concede it is idealistic, but in the face of the immense suffering that goes on every day, suffering from environmental tobacco smoke that causes asthmatic attacks in children who were doing nothing irresponsible themselves, suffering that causes premature death—you've had the emphysematous and the chronic obstructive lung diseases described to you personally by people who have suffered them, the last few years of their lives being incredibly difficult. We must take every effort to stop that.

To that end, I believe you will find that the printed brief presented to you by the Etobicoke board of health makes numerous suggestions, all very valuable, that will help you achieve this excellent effect that we would all like to see. Some of those effects are simply amending technical amendments. I think there's clear agreement that there would be tremendous value in legal photo identification, so I've borrowed some language from the LCBO, because it has worked very effectively for them.

Other suggestions are not simply technical amendments, but they are substantive improvements, points like, for example, recognizing the harmful effects of ETS, or environmental tobacco smoke. Numerous people have referenced that the United States Environmental Protection Agency classified this as a group A carcinogenic in the same category as asbestos. You don't need me to give you further examples. I'm sure everybody around this table is convinced that this is a harmful product.

What are we going to do about it? What about that theme of responsibility? What about that opportunity to do good work? We all must share in that responsibility. Whether we're involved with government parties that believe government should take a more regulative role, or whether we belong to a party that believes government should be less involved but should promote by way of example, I think there is consensus with you, and most important, ladies and gentlemen, with our public that we must address this problem.

We must do it effectively and we must do something real, something substantive. To do that, we need excellent enforcement. There have been laws on our books for over 100 years dealing with this and presently the efforts represented in enforcement make that, quite frankly, even if it does sound a little unprofessional, a joke.

This has been a very divisive issue. You're going to have pharmacists tell you that they are retailers as well as health care professionals. Like some of you here in this room, I sat through and lobbied and advocated for health professionals to have new rights, to recognize new health professionals under regulated acts. The pharmacists wanted to be recognized as health care professionals.

We recommend from the Etobicoke health board that the action with respect to banning cigarettes in pharmacies be implemented within 90 days of royal assent of the Tobacco Control Act. We tell you, as you already have heard and as I'm confident that you know, the professional regulatory body of pharmacists in Ontario gave their members ample warning. They had been working towards this goal for more than five years. The reason pharmacies sought government assistance is because they had an issue of non-compliance.

I would suggest to you that the concept of not supporting a health college this very Legislature has granted regulatory authority to has implications for public safety in and of itself. If we grant them the power to regulate their members: physicians, nurses, pharmacists—and as of January this year, close to 50 different health care organizations are self-regulating—we're going to have immense problems if we don't support the organization we put in place. I'm watching the clock too, Mr Chair.

In conclusion, I would ignore the notes and tell you that you have a wonderful opportunity to do some very good work here today. Please let's not forget that. Let's make this bill as good as we possibly can. Let's remember that at least from a commonplace perspective, most public people, most non-governmental representatives will tell you that if our government and our opposition parties have made a concerted effort, as you have, through this bill and the hearings, you're not likely to return to this issue in short order, you're not likely to amend it any



further. Let's do it right now. Let's make it the best bill we can and let's recognize that we do this not within a vacuum but on a continent where other jurisdictions, other countries, do not take the preventive approach that we do presently. Therefore, we must give this bill all the strength, all the focus and all the opportunity to do good for our children and our adult population within this province.

I'd like to thank you for your attention. In closing, I'd like to say that if I have sounded enthusiastic, if I have presented myself with strong views, I'm appealing to you to recognize that this is all for good reason and that we must make a good effort of the work.

**The Chair:** Thank you very much. I will also just indicate for the record that you have provided us with quite a lengthy brief with specific proposals. We appreciate that. There are a number of members who want to ask a question. Could I ask each to put it into one question, please, because we are short on time, beginning with Mr Wiseman.

**Mr Wiseman:** I don't want to downplay the health side of this, but there is an economic side of this, the question of tobacco smoke and the cost of the medical bill. You made a comment of about \$3 billion in total cost. I actually think it must be higher than that, given all the spinoff and secondary effects. I'd like to know where you got that number.

Just for information's sake for the viewers, the total health care budget in Ontario is \$17.5 billion. The total taxes raised from tobacco last year was in the area of \$935 million, and in employer health tax, the total amount of money that was raised was \$2.6 billion. All of the tobacco money and all of the employer health tax wouldn't even cover the number that you gave us, so I'd like to know your comments on where you got that number and on the costs.

**Mr Bain:** Thank you very much for the question. In a succinct answer, the \$3-billion figure is directly from the ministry. It was in the minister's opening remarks to this very committee. I concur with you that this is a conservative estimate. I will tell you with confidence that the Canadian Cancer Society, Ontario division, financed a study that was recently completed, about eight months ago, at the University of Toronto on the preventive effects and the economic spinoffs.

If you attach to that figure those individuals who are not just absent from work due to direct causes but those individuals who are not free to provide services that our society does not directly pay for—individuals who cannot attend voluntary functions, individuals who cannot be parents, individuals who cannot act in non-employee functions—and you deal with the economic effects of those incurments as well, the study estimated you were looking in Ontario, just within our jurisdiction, at a figure closer to \$7 billion.

It's clearly a conservative estimate, but I went with that conservative estimate because I felt confident that if the government was prepared to use this figure, you would accept it as a legitimate one.

**Mrs Cunningham:** It's an interesting process you've

gone through here. Your board of health has seen the motion and the brief that you've made to city council? This is a representation on behalf of the board of health?

**Mr Bain:** Like most agencies, we work on the principle of majority rule. What that means is that when we pass a resolution, it is not a guarantee that we will not have dissenters or that we will have absolutely every individual saying the same thing, but that when a vote of a majority supports a resolution, we feel free to act on that.

1150

**Mrs Cunningham:** I'm just interested because a lot of the city councils have not endorsed the issue of where cigarettes are being sold, especially in pharmacies, but I'm just pointing that out to you.

I'd like to ask you a question with regard to the statement you've made with regard to licensing, because there seems to be a lot of support for that on behalf of presenters to the committee. If in fact we had licensing, would you go so far as to say that any individual who sells must be licensed? How would it work, in your view? You mentioned the LCBO. We've even had presenters who have come and said that they would go so far as to sell cigarettes out of the LCBO outlets. So perhaps you could comment on either of those things.

**Mr Bain:** Thank you for the opportunity to respond to your question. Specifically on the first point with respect to the sequence of events that brought us here, clearly the Etobicoke board of health is made up of 12 members. In Etobicoke four of those members are city councillors; another five of those members are appointed by the municipality; and another three members, to total 12, are appointed by the Lieutenant Governor on behalf of the province but through a process of mutual appointment. The city undertakes interviewing processes initially.

This particular board felt that it was most important, as we are the regulatory body for the department of health, that we make a strong statement. We are not representing the Etobicoke city council, but you should understand that the mayor of Etobicoke has written a letter not only in support of our presentation but clearly in support of Bill 119. That has been distributed to you along with the brief that the board of health presented.

To your subsequent questions with respect to licensing, extensive research has been done in this area. I believe that if we based our comments on empirical data, all of us would have sounder grounds on which to debate and discuss this matter. The Journal of the American Medical Association, JAMA, article published in 1991 has been quoted by, at last count, at least 18 different agencies that presented to you.

They made it quite clear based on studies done in the United States of America. They surveyed 15 different community programs and they found that the single most effective element was an enforcement program that did not focus on monetary penalties but that focused on suspension of licence in addition to monetary penalties. If we do not have licensed retailers, we'd be in an awfully difficult position to suspend licences. So I suggest that we must recognize the value of licensing

retailers. With respect to your question about the LCBO, it is far more appropriate to use a system that is already structured and already effectively uses surveillance systems and control with respect to who has access. I would like to expand that I have heard some people suggest that pharmacists might be the appropriate people to distribute cigarettes, because of course they can counsel and they already deal with deadly, dangerous products.

I think it is imperative that we all remember that these pharmacists do not distribute dangerous drugs. They're regulated health care professionals. They distribute narcotics, which when used appropriately help people and when used inappropriately have side-effects.

I am not convinced, particularly when I listen to pharmacists talking about cigarette sales occurring in the front of their stores and pharmacies in the back. Although it's a reference, it's not specific to the geography of a store, the concept is that we often have people in the front of the store selling these cigarettes who are not pharmacists. I think everyone on our board had a difficult time accepting that pharmacists would counsel people as they sell every single package of tobacco, so—licensing.

**The Chair:** Final short, sharp question.

**Mrs O'Neill:** I just want to continue with the licensing. I think I asked one of the other municipalities—the city of Etobicoke does not license because Metro does not license. Is that the—

**Mr O'Connor:** Metro licenses.

**Mrs O'Neill:** But Metro has not made the decision to go for licensing of tobacco vendors, is that correct?

**Dr A.M. Egbert:** There is a bylaw in Metro to license facilities that sell tobacco. Metro has a bylaw.

**Mrs O'Neill:** Then may I ask you why Etobicoke has not bought into that plan with the powers they have? Has your board made representation to the council? It would seem to me to be fundamental with the recommendations for substantive improvements that you have suggested to this committee.

**Mr Bain:** In response to that question, a simple yes. We have certainly made that recommendation to city council. We will leave you with a copy of our present municipal bylaw.

I will tell you that your initial comments were not entirely off the mark, that this issue has been discussed and there has been agreement within the department not to proceed on this matter until there is a consensus within Metro. We feel we'd be far more effective acting collectively than acting unilaterally.

But it is a matter that is presently under discussion, and a matter for which there is considerable support in every municipality. We have a liaison committee where all of the boards within Metro try to function consistently, and this particular issue is waiting for the outcome of this bill.

**The Chair:** I'm sorry I'm going to have to end our questioning there, but thank you very much, all of you, for coming before the committee today and for your written presentation.

#### LOVELL DRUGS LTD

**Mr Douglas Sumner:** My name is Douglas Sumner. I'm the marketing manager for Lovell Drugs.

**Mr Michael Niznik:** My name is Michael Niznik. I am a pharmacy manager for Lovell Drugs in Oshawa. In the interests of brevity, I'll skip the introduction to our brief and go directly to our position.

I would like to make it quite well known that Lovell Drugs supports the Ministry of Health's strategy as presented in the Tobacco Control Act as well as most of the proposed amendments and additions suggested to this committee since January 31. We are prepared to work with and support the Ministry of Health to help achieve its stated year 2000 goals.

Lovell Drugs is, however, opposed only to the Bill 119 provision that the selling of tobacco products in pharmacies be prohibited. We believe that the termination of sales of tobacco products in pharmacies should be undertaken on a voluntary basis.

We consider the banning of sale of tobacco products in pharmacies to be discriminatory and of dubious constitutional legality. We would also welcome publication of any studies done by the ministry that would suggest that such a ban would result in reduced tobacco consumption at any age level.

We feel that such a prohibition will have little or no impact on the health of the public, since those who wish to purchase tobacco products will be able to do so in other nearby retail outlets. It is our position that the bill as written will not achieve its major objective, which is to prevent the provision of tobacco to young persons. We feel that it will simply move the sales to convenience outlets or, more likely, to contraband sales, with the subsequent loss of tax income and revenue to the ministry, at the same time developing illegal market acceptance in those same targeted juveniles.

We have in fact over the past two years reduced to seven the number of our outlets selling tobacco products. In light of present marketing trends and sales levels, plans are under way to delete sales of tobacco products in two additional outlets by the end of fiscal 1994.

We are prepared to endorse nearly all of the supplementary initiatives introduced to this forum by colleagues and proponents of Bill 119. We would actively support, first, a total ban of tobacco products—all of our locations are smoke-free as far as employees are concerned; the restriction of the sale of tobacco products to controlled outlets, and our recommendation is that they be taken to the LCBO stores, where the mechanism is already in place; the introduction of legislation that would fine underage possession of a controlled substance; and also any incentive that would relocate responsibility of personal actions as an onus on the smoker, either by education or legislation.

To this point, there has been substantial progress in reducing the number of people using tobacco. Some of this has been achieved by pharmacist-sponsored programs providing public education and counselling. Among pharmacists, there has been a steady decline in those who sell the products, but the decision to date has always been



based on their own volition. Independent studies have always shown that pharmacies are the most responsible retailers of tobacco products. If the reduction of tobacco use among younger people remains the stated objective of this bill, why eliminate the sale from the very group that is least likely to sell to those minors?

**1200**

The economic impact of this legislation on pharmacies in general is defined by the Coopers and Lybrand study which has been well documented to this committee. The immediate impact on Lovell Drugs will be that six to 10 employees will be terminated at once, with the ripple effect of lowered customer traffic to be an ongoing evaluation to determine future dismissals. Profit on the sale of tobacco products, while small, was sufficient to pay those salaries. These employees will be terminated, and since they are entry-level positions, those situations will be permanently eliminated.

I've then included a small table showing the diminution of our sales.

The problem would appear to be somewhat self-solving, as the year-to-year sale of tobacco products, even allowing for 25% to 75% contraband purchases in some of our trading areas, is dropping about 10% to 15% per year, and within a period of three of four years, would not be a viable product line at any of our locations. That kind of moratorium would, however, allow a gradual realignment of our product mix, perhaps without any staff deletions.

The proposed ban will impose further economic penalty on a group of retailers already forced to cope with a series of Ministry of Health economic downsizing initiatives which have had a severe negative effect on our operations. The retail component of pharmacy is not only a separate and distinct entity from the dispensary but is absolutely critical to the financial viability of pharmacy today. In actual fact, the Ministry of Health has itself continuously taken the position that it expects the retail segment of pharmacy operations to cross-subsidize dispensary expenses and overhead that are a part of the Ontario drug benefit plan.

It is our wish that this legislation be amended so that pharmacy is not placed at an unfair disadvantage with competing retailers.

Lovell Drugs further recommends that the Ministry of Health not prohibit any retailer from selling legal products. This present action would establish precedents to encourage other single-interest groups to descend on pharmacy and others demanding that certain products be prohibited.

Legislation of this social significance requires market control prior to usage control. The American experience with the Volstead Act should be a historical window to the ministry regarding both contraband sales and public acceptance.

We have been described as a profession in conflict. We suggest that there is a cognate analogy between pharmacy and government, especially as indicated by the events of the past week, in the application of diverse philosophies to terminate the contraband tobacco market.

At this point I'd like to have my associate, Mr Niznik, make a short commentary on the impact on his individual store.

**Mr Niznik:** The Lovell drugstore which I currently manage is a small pharmacy located in downtown Oshawa. My staff is presently comprised of 13 persons, four full-time and nine part-time.

My purpose in appearing here today is to voice my belief that the ideas behind the Tobacco Control Act are valid and justifiable. However, the intention of restricting the availability of a legal product from only one type of retailer, be it pharmacy or otherwise, is not.

The sale of tobacco products in my store, though modest, generates sufficient profit to pay the salary of one employee. The decision to sell tobacco products is not then entirely voluntary. The loss of these sales would mean the loss of yet one more part-time position. Staff hours were recently drastically reduced due to the Social Contract Act, and further staff reductions could make much of my retail operation unworkable.

As a health professional, I am intimately aware of the dangers associated with smoking. I do urge and counsel patients to quit. If it appears that I and other members of my profession are arguing solely on an economic basis, please remember that it is this economic basis that allows me to deliver my professional services, and I believe as a pharmacist I am very unique as a professional in that sense.

I do support the voluntary cessation of tobacco sales in pharmacies. My own location, perhaps in the near future, may also be able to eliminate tobacco on a voluntary basis. I fear that the legislation as written will not serve its intended purpose, ie, I do not believe that banning the sale of tobacco products in pharmacies will achieve the objective of restricting the sale of tobacco products to minors. I believe it will be the patients themselves who may lose if pharmacies are forced to lower service levels or to close because of legislation.

**Mr Sumner:** In conclusion, I would like to reiterate that Lovell Drugs applauds the ministry initiative with Bill 119, and we urge its passage, but in modified form. Thank you.

**Mr Villeneuve:** Gentlemen, thank you very much for a presentation that I think makes a lot of sense. I want to re-emphasize one statement that you make here: "If the reduction of tobacco use among younger people remains the stated objective of this bill, why eliminate the sale from the very group that is least likely to sell to those minors?" I have to agree with you. Do you have any stores east of Oshawa?

**Mr Sumner:** Yes. In the introduction, which I'm sorry I bypassed, I note we have stores in Whitby, Oshawa, Kingston, Brockville, Cornwall and Ottawa.

**Mr Villeneuve:** How's your Cornwall store doing?

**Mr Sumner:** Our sales have dropped about 85% over the past two years.

**Mr Villeneuve:** Therein is the problem.

**Mr Sumner:** Yes.

**Mr Villeneuve:** Cigarettes by the carton in trunkfuls

of cars are being delivered to high schools. If you have \$22, you're in business. With the events of last week, corner stores in the province of Quebec will now sell you a 24 of beer for a couple of bucks less than in Ontario, they'll sell you a bottle of wine and they'll sell you a carton of cigarettes at half price. We don't need this bill in eastern Ontario at all, even for pharmacies and for corner stores.

However, I think you make a very, very good point when you say a total ban. This product is lethal, there's no doubt about it. It's certainly a cancer-causing agent. Ban it totally, and if you're not going to, then limit it to the LCBO. I agree with that. However, in the area that I represent, with a total ban, you'll never have enough police officers or enforcement people to control what's coming in now from Quebec, Akwesasne and New York state.

**Mr Sumner:** Absolutely.

**Mr Villeneuve:** I rest my case. I agree with you wholeheartedly.

**Mrs Haslam:** Gee, I feel like a lawyer. With all due respect to my opposing lawyer here, Mr Villeneuve is new to this committee. Mr Villeneuve wasn't here yesterday when we were out of the town of Toronto, when 23 people made presentations to our committee and 22 agreed with the legislation, that we should be looking at pharmacists.

With all due respect, we've had presentations from Brantford where they had a questionnaire of students in a secondary school, and 26% to 28% of them said, "Yes, we can get them in pharmacies." So when you say, "The group that is least likely to sell to these minors," I might agree, but we had a 12-year-old in Thunder Bay say: "I got cigarettes. I don't look 18. I'm 12 years old." He did get them from a Shoppers Drug Mart and from a pharmacy. We've had other presenters say that it is available in pharmacies.

My comment on that is, you may be the ones least likely, but when we can stop just one 12-year-old, to me that's worth it. So although I understand pharmacists saying, "We're the ones who can control it the most," it's been proven by other people coming before us that it isn't happening, that they are able to get it in pharmacies. That concerns me when one extra child is hooked on this kind of thing.

When you also take a look at prohibition having little or no impact on the public, again I disagree. Even if we have one person hooked on cigarettes who has to drive a little farther to get those cigarettes and decides it is a little more cumbersome to obtain cigarettes because they aren't available in his pharmacy, if that one person decides to quit smoking, to me that one person's life out of 13,000 people who die every year because of this disease is worth it. It is worth it to the extent of saying, "I don't think a profit is worth the life of that child and I don't think a profit is worth the life of that person who's hooked."

I do commend you that you said in the last two years you've reduced to seven the number of outlets. Any job losses?

**Mr Sumner:** Two at the moment, and with the two outlets that are gone now, there will be another termination.

**Mrs Haslam:** You wanted to delete the sale of tobacco products at two additional outlets by the end of 1994.

**Mr Sumner:** Yes.

**Mrs Haslam:** The college asked you to start in 1990. There was a two-year gap before you started to do that.

1210

**Mr Sumner:** If I may interject, it was approximately one year that it went. There have been some credibility problems with the college.

**Mrs Haslam:** Not according to the college. They made a presentation here.

**Mr Sumner:** I realize that. Little action was taken on several recent initiatives that required their intervention which are not appropriate to discuss here, but I suspect the membership expected that apathy to continue. I have no excuse. I make no further commentary on that, other than perhaps as far as pharmacists are concerned and others, procrastination is a bit of an art form.

**Mrs Haslam:** You're talking about a moratorium. You're saying this type of moratorium over the next—

**The Chair:** Ms Haslam, final question.

**Mrs Haslam:** Okay. You're saying it's absolutely critical to the financial viability, which other people coming before the committee have said it isn't. You talked about, "This present action would establish precedents to encourage other single-interest groups to descend on pharmacy." Single-interest groups like who?

**Mr Sumner:** I shudder to think what's going to happen when the abortion pill is introduced into Canadian pharmacy sales. There is a group out there that is prepared to protest and ban infant formulas.

**Mrs Haslam:** Infant formula doesn't kill people.

**Ms Carter:** Indirectly it does.

**Mr Sumner:** I'm sorry, I was using those as examples of the type of thing.

**The Chair:** I think that has certainly focused on one of the issues. Thank you for your presentation.

CAROL-ANNE FOTY

ELIO ROPPA

**Ms Carol-Anne Foty:** Mr Chairman, honourable members, thank you very much for allowing me to give my views to this committee this afternoon.

My name is Carol-Anne Foty. I am a licensed Ontario pharmacist with 26 years of hospital and pharmacy experience. I'm a graduate of the faculty of pharmacy at the University of Toronto and a member of OCP and OPA. I have been a pharmacist-manager with Pharma Plus Drugmarts at my Etobicoke location for the last 10 years. Present with me today is Mr Elio Roppa, regional manager of Pharma Plus Drugmarts Ltd.

Speaking personally, I have never smoked and actively discourage it for anyone who will listen. My own two daughters sincerely assured me when they were 6 and 8 years old that they would never smoke those yucky,



smelly cigarettes. However, the world changed as they became teenagers and they now lament that smoking monkey on their backs. All my mothering and professional health care advice to no avail, they are learning from their own experience that mom was right about not starting to smoke in the first place.

Let me state at the outset that I am in heartfelt agreement with the intent and direction of Bill 119 to prevent and deter tobacco use and to encourage progress towards a smoke-free society. I know you have heard many of the same arguments pro and con from many witnesses who have presented already. I sincerely hope you will truly hear the blunt reality of our store's situation.

At our Pharma Plus location in Etobicoke, our community pharmacy has serviced the area for upwards of 30 years. Our clientele includes close to 70% seniors and welfare recipients. We are a diabetic training facility, recommended to patients by St Joseph's and the Queensway hospitals. For my clients at the dispensary, we are essential health care professionals. Our store however is also a retail outlet, the front shop physically abutting a large Dominion food store which also sells tobacco products.

I know that if Bill 119 is passed in its entirety, forbidding us from selling tobacco in the front shop, our store may well close. Tobacco products currently represent 8.6% of our total gross sales. Our retail sales in this terrible recession are simply not strong enough to sustain such a blow. My job, as well as that of our other full-time pharmacist and 16 other full- and part-time employees, is on the line.

Furthermore, I doubt that our smoking customers will stop smoking or be deterred from smoking by our demise. They will simply go next door. Also, the loyal elderly clientele, who trust me, who depend on our services, will be left hanging. Like it or not, we are a retail operation that depends on front-shop revenues to pay the bills, especially since ever-diminishing ODB payments have minimized our operating margins.

My children are typical of most young people. They and their friends assure me they would never bother to buy their smokes from any pharmacy simply because cigs are too expensive there and they would always be ID-ed. The corner convenience store was always cheaper and a ready source.

If the legislators are truly sincere in their approach to deterring tobacco sales, they should not strangle one type of retailer when it will make absolutely no impact on resolving the problem. At the same time, I applaud those retail pharmacies that were and are able to voluntarily discontinue tobacco sales. I am sure they did not jump off a limb in faith for this decision, but reviewed their marketing and fiscal position carefully beforehand. Not all retail pharmacies, however, have the luxury of optimum market vectors to make that same decision.

I practice in a retail location that depends on front-shop revenues. For my clientele I am available for free health care consultation 12 hours a day, all day long. I do not sell cigarettes at the dispensary and I do provide anti-smoking counselling to all who seek my professional advice. My customers do not confuse my practice as a

caring health care provider with what is sold at the front of the store.

In closing, let me point out that the practice of pharmacy has evolved dramatically over the years. We will continue to evolve towards that pure practice of pharmaceutical care where some day we won't have to look at the profit margin of the front shop for survival. Until we develop a different way of being paid for our professional services, we will be linked to retail products and the front shop. It is my fervent hope that the positive and progressive focus of Bill 119 is kept, while the untimely, unfair and misdirected aspects are reworked.

Thank you for the opportunity provided in this democratic platform for presentation of my perspective. I welcome any questions you may have.

**Mr O'Connor:** Thank you for your presentation and your thoughts. My son is now 7—he had a birthday on the weekend—so he fits into that range, and I hope that right now, knowing that I'm involved in the tobacco issue, he doesn't want to start smoking. He thinks it's yucky, just like your children did, and maybe at that point somewhere down the future he wouldn't then be turning around to some sort of situation where maybe he'd be turning to his parent for the purchase of that product.

It must be really awkward for you to sell the product in your store when your children, whom you counselled not to take up the habit—here you're pleading that the economic impact that you face is something that your children can help you with by coming in and buying this deadly product. I guess it's a real difficult situation.

We had some college grads. We got a wonderful little presentation that was left on our desks this morning by the graduating class of the faculty of pharmacy. It was a response to Bill 119. We actually had a group of pharmacy students—right now, they're probably writing their exams actually—and they lined up right across the front there and sat here and made a presentation to us. Every one of them was committed. They were health care professionals. They wanted to go out and be involved in health care practicioning and be part of that.

I guess you're trying to paint a little different reality here, and if you had then the opportunity to speak to this graduating class of health care professionals, people who wanted to go out there and provide for optimum health care for the benefit of the people who come in to see them—they don't see them as consumers in a retail market; they see themselves as somebody who's going to be involved in health counselling—what would you say to them when—they're young, they don't have children, in most cases—somewhere down the line saying that you're going to have to swallow your pride and maybe sell these lethal products to your children some day?

**1220**

**Ms Foty:** That's exactly the opposite of what I just presented. I said that we are evolving towards the pharmaceutical care where we will not have to depend or look to the front-shop revenues. I agree totally with the optimism and the goals of university and of all my colleagues. I am not opposed to dealing with the social

evil that is tobacco. I loathe it. I cut my kids' allowance off because I suspected they might be buying tobacco, let alone never allowing them to ever think of buying it in my store. I did not sell it to them. I think it's a terrible thing.

What I'm saying, as you would hear in my presentation and from many other people who have presented their arguments, is that the timing is terrible. You're cutting off our hands and our feet to deal with an issue so that the government can look good and so that an easy goal is reached to look good. I agree with the college's stance. I just say we need more time to develop it thoroughly.

I cannot but be offended by the aspect that I am less of a health care professional because I work in a place that also has tobacco products for sale. I think it's a very short, naïve stance to pick on that aspect. It's not dealing with the problem really. To deal with the issue is very complicated. You don't cure a brain tumour by cutting off the head. It's a complicated aspect. You have to look at the health, the goals for health, for the future health of the individual or of the profession.

**Mr McGuinty:** Thank you for your presentation. What are we going to do with you pharmacists? We've had, as you know, a number of presentations made by pharmacists representing both sides of this issue. My understanding is that there are about 1,400 out of 2,200 pharmacies which continue to sell tobacco products—1,400 out of 2,200.

Let's say that we eliminate Shoppers Drug Mart. That brings us down to 1,100 out of 2,200. Half of the pharmacists in this province are selling tobacco products. I'm sitting in opposition, but as a government member I'd certainly be very concerned about wading into an area where there is no consensus.

I don't believe that, by and large, pharmacists are any more careful in terms of selling tobacco products to kids, and I really have difficulty with the idea of pharmacists selling tobacco at the front end and counselling at the back end.

But where I do agree with you is this idea that—first of all, I think everybody agrees as well that we're not going to reduce overall the usage of tobacco as a result of eliminating it from our pharmacies. There are 120,000 cigarette retailers in the province. We're going to reduce them, when we cut them out of the pharmacies, by about 1%. If there are 100 in town, we're going to knock it down to 99 locations now, which I don't think is going to be significant. Nobody suggested it is.

What they're saying is that the symbolism here is important. To tell you the truth, for me, and you can comment on this, the symbolism is not so much whether my four kids can go to the pharmacy and get cigarettes. The symbolism for me is that now I'll simply be telling them, "Look, it's not illegal for you to smoke." I've got a problem with that. My kids smoke and it's not against the law.

The other problem I've got is in terms of the mixed messages: "Just wait until you're 19. It's true it kills you. It causes all kinds of health problems and you're likely to

contract some kind of inoperable cancer. But just wait until you're 19." That's the problem I have. That's the big picture. That's the mixed message that I have a great deal of difficulty with. I just don't see how eliminating it from pharmacies helps to deal with that.

**Ms Foty:** I dare say it's a very addictive habit and substance, and the government is also addicted to its revenues. I think it's very hypocritical to be dealing with it at this one level. You know, they ask us to bite the bullet and be the sacrificial lamb, to give up our jobs. My children won't finish university. The university kids who are working part-time for me will have to forget about continuing. Of course, I'm speaking as a typical example, a little segment, pie, of the population that's going to have these ramifications to live with.

The aspect is that it is not going to cure the social ill. It has to be dealt with more thoroughly. Deal with the manufacturers. Deal with the source. You know, put it in LCBO stores. Prohibiting it outright is going to lead to an explosion of contraband, I agree, but it just is hypocritical to me, when the government needs the revenue from tobacco sales, to say that we can't survive and we should be the sacrificial lamb. It doesn't appeal to me.

**Mr Villeneuve:** Thank you for your presentation. I think you've put to rest the conflict of interest that was brought forth a little earlier, and I'm glad you touched on it because that's an important aspect. Whether it's symbolic, political correctness or whatever, I think you've clarified that.

Your tobacco sales are something less than 10% of the total revenue. Have you seen that drop in the last five years?

**Ms Foty:** I think so, definitely.

**Mr Elio Roppa:** In the last two years there has been a drop.

**Mr Villeneuve:** So you quite obviously, in spite of the fact that you're in downtown Toronto, which I gather you are—

**Ms Foty:** Etobicoke—Islington.

**Mr Villeneuve:** To someone from eastern Ontario, downtown Toronto is a long way around. Would you attribute the total area here of your reduced sales to fewer smokers or more smuggling?

**Ms Foty:** In tobacco?

**Mr Villeneuve:** Yes.

**Ms Foty:** In our area?

**Mr Villeneuve:** Yes.

**Ms Foty:** I can't say because I don't pay attention to tobacco sales; I pay attention to the dispensary. Sales are down across the board in our store. Our Ontario drug benefit recipients, however, are high. But as far as the reason for the loss—

**Mr Roppa:** I would attribute that mostly to smuggling.

**Ms Foty:** Yes.

**Mr Villeneuve:** Mostly to smuggling.

**Ms Foty:** They're welfare recipients. We've had two or three break-ins going for the cigarettes. Never mind



the narcotics any more; just get to the cigarettes and load up the shopping bags and break thousands of dollars worth of plate glass.

**Mr Villeneuve:** Now, if Bill 119 were not to be implemented, and I guess it will probably have across-the-board support—certainly we would like to support it with some amendments, but we may have the opportunity. If your sales continue to dwindle, which they have, in tobacco products, there will come a point where you will say, "It's not worth it." You've had some break-ins. Do you feel you're far from that decision?

**Mr Roppa:** Let me answer that one. In this particular location, we do rely on tobacco. If it wasn't for the tobacco sales, we would more than likely close the store.

**Mr Villeneuve:** That's pretty final.

**The Chair:** Thank you both for coming this afternoon. We appreciate your presentation.

We stand adjourned until 2 o'clock this afternoon.

*The committee recessed from 1228 to 1404.*

#### NORTH YORK PUBLIC HEALTH DEPARTMENT

**The Chair:** Our first witnesses this afternoon are from the North York public health department. Welcome.

**Mr David Shiner:** Maybe I'll start. I'm David Shiner. I'm a councillor in the city of North York and I am chair of the board of health. Dr Graham Pollett is our commissioner and medical officer of health, Fred Ruf is our director of environmental health, and Romilla Gupta is our tobacco policy analyst. You gave us four chairs and we filled them for you.

As chairman of the board of health for the city of North York, I would like to thank this committee for the opportunity to speak on a subject of vital importance to the city of North York. I commend the government and the two opposition parties for the support provided in bringing Bill 119 to this committee for hearings.

We're here today to make a strong appeal to you to forge ahead with Bill 119 and provide the protection the public needs from tobacco industry products. The evidence has been stacked up against tobacco companies for many years. The human toll from tobacco use is enormous. Tobacco is poisonous and addictive. It kills more than 13,000 people a year in Ontario. More than 36,000 children in Ontario take up the habit each year. This is entirely due to the massive tobacco product promotions directed at young children by the tobacco industry.

Past governments have passed on taking action to curb the tobacco epidemic. Tobacco is not a matter of personal choice, as the tobacco industry would like the public to believe. It is a highly addictive drug. The Addiction Research Foundation in 1991 concluded that tobacco use is as addictive as heroin.

The tobacco industry's marketing techniques appear to focus on enticing thousands of young Canadians to become addicted to tobacco. Statistics tell us that people are exposed to tobacco company sponsorship ads at least 295 million times each year. Children must not be taught to deal with stress, low self-esteem and poor body image by turning to cigarettes.

Finally, this government has had the courage to take a

stand on the issue and not be discouraged by the predictable criticism and opposition that has come from the tobacco industry and tobacco retailers. By the passing of Bill 119, the public will be assured that this government is dedicated to protecting the public and preventing yet another generation of young children from becoming addicted to tobacco.

One does not have to be particularly astute to appreciate the utmost importance of passing tough legislation to prohibit youth from buying cigarettes. Children have little or no difficulty buying their cigarettes.

Bill 119 recognizes the importance of delaying young children from starting to smoke. If you haven't started to smoke by the age of 19, the chances are very small that you will ever smoke in your lifetime. We fully endorse the provision in Bill 119 which raises the legal age of purchasing tobacco products to 19.

We recommend one amendment to Bill 119, which is that a licensing system for tobacco retailers be established. This would prove to be a more efficient and effective means for dealing with violations and convictions in that the licence can be removed temporarily or permanently. A court order to remove the right to sell tobacco products, as required under the present wording of the bill, we believe is a lengthier and more bureaucratic process.

For children and teenagers, the inconsistencies in policies related to tobacco are very clear. How can they take our smoking prevention efforts in the school seriously when on the one hand we emphasize the importance of not beginning to smoke, and on the other hand they see tobacco products being sold in the pharmacies, see people smoking all around them in restaurants and malls, and know they can easily buy a pack of cigarettes from the local corner store or from a vending machine.

To add to the presentation today, what really concerns me is children. Even on my way in to the office this morning, I passed by a school, and standing outside, seven-, eight- and nine-year-olds were smoking. You pass by a high school and they're smoking outside. Yet when I walk into a store, prominently displayed is a sign saying it's illegal to buy cigarettes. But in checking, I can't find any convictions. What's the sense of having a law that isn't enforced?

#### 1410

It's actually from your own information. Just a few of the statistics that really alarm me are: Smokers rarely begin their habit after the age of 20; according to the Addiction Research Foundation, 24% of students in grades 7 to 13 smoke; as well, in 1991, the percentage of young people trying tobacco for the first time before grade 9, and it's illegal to buy it at that age, was 69%, and from 1991 to 1993 the percentage increased from 69% to 75%.

The way the bill is written now, if I'm correct in my interpretation, you have to be convicted in court twice before you lose the right to sell cigarettes for six months. You really don't make the retailer put any emphasis on having to ask for identification. If you're a smoker and it's legal, you don't mind showing identification at 19 or

20. But the way it is now, it'll be the same; it'll just continue to be where kids walk in and ask for a pack of cigarettes and there really is no harm to the retailer if he sells them. Who's out there, a bylaw enforcement officer? No one's out there from the courts. No police are out there laying charges.

I think licensing will really help. I think that if someone knows that if they are caught selling a package of cigarettes to an underage person they could lose their licence on the first offence for six months and on the second offence permanently, they'll know it will hit them in the pocketbook. They don't have to go through the courts. They don't have to be convicted over and over again. You don't have to fill up the court system with it. You have to have something a retailer could lose and you have to affect them where it will hurt them most, which is in the pocketbook. If they don't have cigarettes, they don't have the draw to the stores and they won't make the profit. They'll notice it's there.

Really, I think it's time to put an end to the hypocrisies once and for all by passing an amended Bill 119.

Dr Pollett, North York's medical officer of health, will now address you on a second amendment we propose for Bill 119.

**Dr Graham Pollett:** The second amendment we recommend for Bill 119 deals with the environmental tobacco smoke issue. Environmental tobacco smoke kills more than 4,000 Canadians each year. In 1992, the United States Environmental Protection Agency classified environmental tobacco smoke as a group A, or known human carcinogen.

Bill 119 takes the approach of specifying places where tobacco smoking is prohibited. Unfortunately, this approach allows smoking to occur unregulated in a considerable number of public places, including restaurants, entertainment facilities and shopping malls.

The city of North York recently passed its new environmental tobacco smoking bylaw. During the consultation process that took place while drafting the bylaw, a major concern identified by the business community was the existing lack of consistency in non-smoking regulations across jurisdictions. Business operators expressed the need for a level playing field, as they put it, in non-smoking regulations; that is, they asked, why should a restaurant on one side of the street be subject to legislative requirements which differ from those restaurants on the other side?

Bill 119 offers a golden opportunity to once and for all offer the needed protection to the public from environmental tobacco smoke. We recommend that Bill 119 reverse the onus of definition to those places in which smoking would be allowed. We further recommend that in all cases where smoking is permitted, smoking be restricted to a designated smoking area, which would be required to be fully enclosed and separately ventilated to the outdoors.

In closing, we would like to congratulate you again for the leadership you have demonstrated in proposing one of the most comprehensive and toughest pieces of anti-smoking legislation in the world. In our view, the recent

decision by the federal government to reduce tobacco taxes makes the passage of an amended Bill 119 an urgency. Passage of an amended bill would send a clear message to the people of Ontario that this government is seriously committed to protecting the public from the hazards of tobacco products.

**Ms Carter:** Obviously we all have the same main objective, which is to prevent children from starting to smoke. That's been very clearly identified and that is what the bill is aiming at. The question is how to do that. You mentioned some things and I'd like to go into that a little bit further.

First of all, you mentioned that a business can only be closed after two convictions; I believe that's within a five-year period. You obviously don't feel that is sufficient and that it would be better to have a licensing system. Could you say a little bit more about why you think it would be better to have a licensing system?

**Mr Shiner:** When I tried to find out the number of convictions under the current legislation, which makes it illegal to sell cigarettes to someone under 18, I couldn't find offences, and I'm looking at not just the system that's in place but how you enforce the system. If you're talking about someone having to be charged, having to go to court, having to be convicted once, and then hopefully they would be caught a second time and after a second time they're only suspended for six months, I don't think, in my personal opinion, that if I was a retailer that would really deter me or make me tell my staff to be on guard when someone asks for cigarettes, to show me identification if I'm in doubt about their age.

I know that if you buy liquor products you have to show your proof of age. If you go to a bar you have to show your proof of age. There's no proof of age required now that I know of, nor do I see people asking for it when they go to buy cigarettes. I think the onus has to be on the vendor to know that it's his responsibility to ask for it, and that if he doesn't ask, it could cost him seriously by losing the right to sell that product.

**Ms Carter:** Some people have actually suggested that sales of tobacco should be confined to the LCBO outlets. Do you think that would be a good solution?

**Mr Shiner:** As long as cigarettes are legal, then you have to decide where you can allow them to be purchased. We're already controlling where people can smoke them, but I don't think it's the same as having to put it behind the counter, only give it to the LCBO, because you may then be perpetrating a larger contraband market out there where people just sell them out of their trunk. I understand that even now with kids at school, one kid will buy and other kids will buy cigarettes from him. They buy individual cigarettes. They're able to do that.

**Ms Carter:** Kiddie packs. Another suggested strategy is having plain, unattractive packages and I understand that our Health ministry is talking to the federal government about that, because that's something that would be better done at a national level. Do you have any opinions on that as a strategy?

**Mr Shiner:** I think it's a good idea to have a plain



package and I think what you're doing is correct; I endorse that.

**Mr Jim Wilson (Simcoe West):** Just before I thank the group, I want to apologize to members for not being here this morning, but I was in the city of Barrie, in which the county of Simcoe was awarded the International Plowing Match for 1997, so that will be—

*Interjections.*

**Mrs Haslam:** Mr Villeneuve so accurately mirrored what you would have said here, Mr Wilson. Your choice of replacement was uncanny.

**Mr Jim Wilson:** Thank you. We try to be consistent on this side, Mrs Haslam.

**The Chair:** All that being said, Mr Wilson—

**Mr Jim Wilson:** Thank you very much to the North York public health department. I just wanted to know whether you have any university or college campuses in North York.

**Mr Shiner:** We have York University, and I have a letter that came to my office this week—

**Mr Jim Wilson:** That's what I wanted to ask you about.

**Mr Shiner:** —concerned about even the lack of areas for them to have smoke-free environments.

**Mr Jim Wilson:** Right.

**Mr Shiner:** I've sent that to the medical officer of health, so we will deal with that.

**Mr Jim Wilson:** I think all members have probably received a similar fax or the letter. Do you want to make any comment on that at this time, because they're looking for an exemption to the banning of smoking in post-secondary institutions.

**Mr Shiner:** I know that our city is moving towards a total ban on smoking, but we're trying to work with the public out there. We were very successful in working with the shopping malls, to come to an agreement with them and the restaurateurs as to where smoking would and wouldn't be allowed, and you did not see the uprising and vocal chorus against the city of North York when it enacted its smoking bylaws, which are extremely tough and extremely tight. If that's what York University is looking for, I'm sure we'll be considering that very seriously.

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**Mr Jim Wilson:** Could you explain what the current bylaw is and how it affects the university now?

**Mr Shiner:** Fred, would you like to cover that?

**Mr Fred Ruf:** I'll respond to that. The current smoking bylaw makes it illegal to smoke in public places or areas which are not separately ventilated. For example, if we take into account an area like a public mall, there's no smoking in the mall, but the operator can designate up to 25% of that floor space for smoking provided it's fully enclosed and separately ventilated.

York University, which you refer to, is an interesting case. We are working with the York University administration to work out some details where smoking is permitted in bar areas or lounges—they refer to them as

student lounges—where the student lounge is served by the same ventilation system as some classrooms. So herein lies a real dilemma.

**Mr Jim Wilson:** I can see that being a problem.

**Mr Ruf:** A real problem, so we're trying to work out a way where they can either separately ventilate the lounge or simply ban smoking entirely if it impacts on the classroom.

**Mr Jim Wilson:** What about in the dormitories or residences?

**Mr Ruf:** I'm not aware that there are any rules or regulations against dormitories. Those will be private residences.

**Mr Jim Wilson:** Could we just check that with the parliamentary assistant, whether the residence rooms are considered private residences? At York it's all kind of in one area.

**Mr O'Connor:** That's something we haven't got put in. It would be something we'd be looking at in regulations. If the committee members here want to make some recommendations, I'd be willing to listen to them. In talking to one university that called me, I welcomed the opportunity for them to send me off a letter, something that they've talked about with their residences, that if they wanted an amendment, we're certainly be amenable for something to happen.

**Mr Jim Wilson:** Would there be any objection from your department if we were to exempt the residence rooms—as you said, now it's not effective anyway—as it's considered a private residence?

**Mr Ruf:** I'm not sure they would be covered by our existing bylaw. I would interpret that to be a private residence. However, we certainly wouldn't object to your considering that.

**Mr O'Connor:** On the licensing, this is all part of a problem that we have somewhat around the interpretation and enforcement. The key here is that we want to have something that's enforceable.

To me, a licensing system could entail some areas that would allow grace periods, would allow time for retailers to comply, of course delaying the effects of the bill, tribunals and hearings, so that if there is discussion or a discrepancy, they've got that sort of appeal process, plus then maybe a court process afterwards. We could be delaying things for a much longer period of time than what I see is something that is spelled out fairly clearly and concisely.

I'd welcome your comment on how you could maybe see yourselves as being part of the enforcement. I'd just suggest that you take a look at section 3, and maybe we need to change some of the wording on it, around the provision of selling to young people. I think it's pretty clear but I know I've got some difficulty around section 2. It just seems that the wording is a little bit awkward and maybe we'll have to amend that somewhat, but to me the direction is pretty clear, and maybe the photo ID is the way to go, but it's clear that anyone under the age of 19 will not be sold or even given cigarettes. On the enforcement, if you can see a role for yourselves there, I'd certainly appreciate that.

**Mr Shiner:** I think the intent is there and I commend you on the intent. That's not the perspective I'm coming from. I'm saying what I said before, knowing that you know there's a problem. We license dry cleaners. It's a Metro licence. We license hot-dog vendors. If they don't follow their regulations, they could lose their licence and they're out of business.

**Mr O'Connor:** That's why I asked you about the role. You're part of Metro. You would have a licensing system as opposed to going to a large bureaucratic problem of trying to come up with a provincial licensing system. Is there a role for you in there?

**Mr Shiner:** I haven't made the statement that you have to operate the licensing system.

**Mr O'Connor:** I appreciate that then.

**Mr Shiner:** At tomorrow's council meeting this item is on the table. I believe you had a deputation this morning that also talked about licensing. I was the one who put it to the board of health two weeks and sent it on to our council, where I'll be putting a motion forward asking Metro to license.

Remembering the levels of government as I do, and my post on the totem pole, which is what I have, we're a city government. We're very close to the people but it's very hard to enforce our regulations even in the malls. Our enforcement is to bring a charge against the mall owner if he allows somebody to smoke. We can't call the police in to lay a charge. There's no smoking police. We can talk about what we want to do and we can enact, and with the help of the mall owners and the restaurateurs we have some bylaws in place and they are going along with them and cooperating.

I think that licensing, and I don't have all the areas worked out, is the avenue to go. If you're driving a car and you have a conviction or two, you don't worry about it, but once you get eight or nine points you say: "I could lose my licence. I'm not going to do this any more." People tend to slow down until they get their points back, if they're habitual at it. If they keep doing it, they lose the right to drive and I'm looking at the same thing.

I'm trying to make a simple system out of it, not a complicated one. I don't mind if you give the jurisdiction to municipalities to carry it out, those that have licensing in effect now.

I don't have the means worked out for it. I don't come to you with a solution to the problem completely. I just come to you and say that if I was store owner and you told me that I had to pay a minimal amount for a licence, and that if I sold to minors or if I sold contraband cigarettes, which is another problem that's being wrestled with, and if I had a package of those there, I could lose my licence for six months, and if I knew those cigarettes were not only a large cash producer from which I made money but attracted people to my store to buy their bread, their milk and their incidentals, which is all they come for in many of these small stores, I'd be concerned.

If I lost it once and I knew it could happen a second time for more than six months I'd be extremely concerned about that happening to me.

**The Chair:** Thank you all for your presentation.

#### COLLEGE OF DENTAL HYGIENISTS OF ONTARIO

**Ms Evie Jesin:** I'm Evie Jesin, a professional member for the College of Dental Hygienists of Ontario, and assisting me with this presentation is Maria Lee, a public member for the College of Dental Hygienists of Ontario.

With the proclamation of the Regulated Health Professions Act on December 31, 1993, the College of Dental Hygienists became the regulating body for the profession of dental hygiene. This college governs 5,000 professional dental hygienists in Ontario whose primary mission is to promote the health of the people of Ontario through the practice of preventive oral health care.

As primary health care providers, dental hygienists recognize the adverse effects of smoking. This presentation will serve to officially register the College of Dental Hygienists' support for Bill 119, An Act to prevent the Provision of Tobacco to Young Persons and to Regulate its Sale and Use by Others.

**Ms Maria Lee:** First of all, we want to congratulate the government for bringing this bill forward, and the opposition parties for supporting it. The College of Dental Hygienists of Ontario is a member of the Ontario Campaign for Action on Tobacco with all major Ontario health organizations. As a member of OCAT we support the recommendations in the brief presented to you by the coalition.

In particular, we support the banning of the sale of tobacco by licensed health care professionals such as pharmacists. We believe that pharmacists should not participate in any advertising or promotion which may encourage the use of tobacco. As a regulated health professional body, we firmly support the Ontario College of Pharmacists' position in removing tobacco sales from drugstores.

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**Ms Jesin:** In addition, the proposed legislation has no provision banning the sale of chewing tobacco. The College of Dental Hygienists would like to have such a ban included in the legislation because of the serious harmful effects of chewing tobacco.

This presentation will focus on the profound ill effects on the tissues of the oral cavity caused by smoked and smokeless tobaccos. The impact of tobacco use on precancerous oral diseases and other oral conditions, as highlighted in the comprehensive review by Christen, MacDonald and Christen in June 1991, will be discussed.

The scientific literature has identified a number of intraoral malignancies and conditions that have been directly or indirectly linked to the use of smoked and smokeless tobacco. Regardless of whether the tobacco is chewed, smoked as a cigarette or cigar, sucked as smokeless tobacco or reverse-smoked whereby small quantities of tobacco are placed in the mouth between the cheek and the teeth, the health of the individual is harmed. Both smoked and smokeless tobacco are considered to be prime causes in the development of the precancerous condition known as leucoplakia. Referring to photograph 1, leucoplakia is observed to consist of a whitened, thickened patch or lesion, usually located on the inside of the cheeks, floor of the mouth, corners of



the mouth, borders of the tongue or the tooth ridge.

The scientific literature addresses the positive correlation of the condition of leucoplakia to the frequency, amount and length of tobacco use. The highest prevalence is seen in pipe and cigar smokers. A site-specific association occurs between leucoplakia and the area where smokeless tobacco is placed. Furthermore, research indicates that leucoplakia has a definite but undetermined risk of malignant transformation and that most oral cancers are related to the oral habit of smoking.

Photograph 2 is a clinical picture of nicotine stomatitis, whereby the roof of the mouth of a smoker exhibits red lesions, representing the irritated salivary glands surrounded by a white ring. Reverse smoking, whereby the lit end of a cigarette is held commonly in the mouth is associated with nicotine stomatitis. Dental hygienists, as primary oral health promoters, work with clients to change their smoking and tobacco habits.

A number of comprehensive reviews have discussed the cause and effect relationship occurring between tobacco use and a variety of periodontal or gum diseases and conditions. There is strong evidence that smokeless tobacco use causes direct damage to the gum at the site where the tobacco is held, between the gum and the inside of the cheek. Furthermore, localized gum loss and bone loss may occur at that side.

Photograph 3 depicts a client with gum disease associated with the habit of smoking one pack of cigarettes per day. Photograph 4 shows a smoker with severe periodontitis, which is characterized by bone loss, loosening of teeth and an increase in pocket depth. The scientific literature contains many studies which correlate the increased acceleration of bone and tooth loss to the more tobacco the individual uses.

Photograph 5 represents acute necrotizing ulcerative gingivitis, commonly known as trench mouth or Vincent's infection, which is more often associated with smokers than non-smokers. Research has indicated that it is possible that the chronic exposure to nicotine may contribute to this disease by restricting the delivery of oxygen to the affected tissues. The clinical picture of individuals with acute necrotizing ulcerative gingivitis is one of painful, bleeding, ulcerated gums and extremely offensive breath. Heavy smoking, high stress levels, emotional anguish and oral self-care neglect contribute to this condition.

Numerous clinical investigators have concluded that both adult and adolescent smokers have higher levels of calculus above and below the gum line than do non-smokers, which in turn may be correlated with poor oral self-care practices. Photograph 6 highlights intense calculus formation on the teeth of a smoker whose habit consisted of smoking two packs of cigarettes per day.

Tobacco smoking and smokeless tobacco usage are common causes of offensive, stale and unpleasant odours. Brown to black staining of tooth enamel, dentures and dental restorations are commonly found in smokers, as depicted in photograph 7. Many of these stains penetrate into the tooth enamel and dentin and are associated with the accumulation of large amounts of plaque and calculus on the tooth, in conjunction with poor oral self-care

practices, as depicted in photograph 8.

Dental hygienists can remove these deposits and stains, as is seen in photograph 9, but the avoidance of tobacco products would prevent the problem. Chewing tobacco and associated staining of teeth are seen commonly in major and minor league professional baseball players.

Photograph 10 depicts the association of cigarette smoking with increased caries or cavity rate. The smoking process alters the oral flora and causes increased changes in tooth structure. From clinical observation, adolescent and adult male smokers have more plaque than do comparable non-smokers. Dental caries is also associated with smokeless tobacco use, especially because of the sugars contained in the smokeless tobacco, which may result in more cavities.

The habitual holding of the pipe stem in the same position will cause dental abrasion or the wearing away of the hard enamel tooth surface. Furthermore, the weight of the pipe stem may promote tooth drifting and cause spacing to occur between the teeth.

Heavy smoking predisposes the smoker to develop a yellowish, white, brown or black fur-like coating on the upper part of the tongue, commonly referred to as hairy tongue, as seen in photograph 11. As more and more debris becomes trapped in this fur-like coating, a burning sensation can occur on the tongue, coupled with bad breath. Numerous studies have shown that the ability to both smell and taste is diminished among smokers.

In conclusion, the slides of this presentation highlight the adverse effects of tobacco use on the tissues of the oral cavity. The College of Dental Hygienists of Ontario fully supports Bill 119, as it will impact positively on the health of young persons.

**The Chair:** Thank you very much. As a veteran of the hearings on the RHPA, I can recall slides that dental hygienists and dentists and others brought in. I can recall always saying to myself, how could anybody view that and then waltz out and light up again? I don't know what the reaction of my colleagues has been, but you just take one look at that and say, "There must be an easier way to live my life."

I thank you for that, even though it's hard to look at, because it's the first time we've really addressed, in a very specific way, a number of these issues. If members' stomachs have settled, I'll now turn for questions.

**Mr McGuinty:** I had been looking forward to a big dinner this evening, but maybe I'll pass and have a glass of water or something.

Tell me, can you notice signs of tobacco-related problems in the mouths of young people?

**Ms Jesin:** We notice problems of tobacco in all our clients. That includes young adolescents and adults in general.

**Mr McGuinty:** You described a number of conditions there. What's the most likely condition or the one you'd see the most in a young person who's smoking, and how much do they have to smoke before these telltale signs become apparent?

**Ms Jesin:** It's very apparent. You can always tell a

smoker from a non-smoker because of the brown staining that occurs on the teeth. That is the first indication that someone is a smoker. The second will be the irritation to the tissues, the gum tissues, and then the consequences of periodontal breakdown, gum breakdown.

**Mr McGuinty:** I gather there are additional costs associated with cleaning a smoker's teeth as opposed to a non-smoker's teeth. Is that right?

**Ms Jesin:** Perhaps the time. There is a responsibility factor and there's a time factor, and when you have a lot more staining, especially the brown heavy staining, as you see in the slides—incidentally, seven of the 11 slides are of my own clients whom I have treated. I can tell you that it does take longer. It takes more pressure. It takes more strokes. There may be more discomfort to the client because of the time factor involved and the number of strokes to scrape off the stain.

**Mr McGuinty:** Do you consider it your mandate or obligation to raise this with any of your clients? I'm not suggesting that you should, but I'm just wondering, what is your approach to this?

**Ms Jesin:** As a dental hygienist I have an obligation to make an assessment and to inform the client of that assessment, that their teeth are brown, that their tissues are red. I also go through oral self-care with them. We assist them so that if they don't want to floss every day, we try to work with them. It is our obligation to inform them of the changes that are occurring in the mouth directly related to the smoking.

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**The Chair:** Ms Carter, before you begin, just to finish that thought off, in terms of your clients, if you go through all that, then do you find that some of them actually stop, or is it your experience that because of the addictive nature, the tragedy is that no matter what you do or say to them, they continue?

**Ms Jesin:** Many of them stop, especially when they come in saying, "Look, I want the brown stain off my teeth," as these slides depicted. Then they do get them white, but some of them light up a cigarette right there in the reception before they pay the bill.

**Ms Carter:** In these hearings yesterday, which were out of town, we were listening to some people who were involved with the educational approach to preventing children from starting to smoke, which seems to meet with mixed success. There are different things that they highlight to discourage kids from starting to smoke. Is this kind of information ever used in those kinds of educational materials, and if not, should it be?

**Ms Jesin:** Yes. I happen to be a coordinator of one of the community colleges that teaches dental hygienists. In fact, it's the largest program in Ontario. In that program, we encourage our students to develop flip charts that include pictures like the ones I have demonstrated today, which they use with their clients in showing them the effects of smoking. As far as education is concerned, dental hygienists are trained to do that and to take part in that activity, both at the educational level and throughout their clinical practice.

**Ms Carter:** We are trying to counteract the cool

image of Virginia Slims and the young beautiful person who is going to be even more cool and beautiful because they smoke.

**Ms Jesin:** Absolutely. As I said, my students make flip charts. I'm fully aware that many offices have other audio-visual aids to depict the ill effects.

**Ms Carter:** If somebody starts to smoke really young, and we're hearing that this is indeed the case, that people do start at very early ages, what is the outlook for a person as far as mouth problems are concerned if they start smoking, say, at the age of nine or 10?

**Ms Jesin:** Some of the stains will penetrate into the tooth, and they will not be able to be removed. We can only remove those stains that are extrinsic, on the outside, but with time they will penetrate. If they are smoking for long periods of time, then the teeth will never appear clinically white. There may be associated cavity formation and then further tooth breakdown related to that and gum disease. Gum disease is the number one reason why teeth are lost right now, because fluoride, as you know, has taken care of a lot of the cavities.

**Ms Carter:** At what kind of age might that happen?

**Ms Jesin:** It peaks around 35.

**The Chair:** Thank you for coming before the committee, even if you did perhaps disturb our lunch a little. It was effective and we appreciate it.

MICHAEL GASPAR

**Dr Michael Gaspar:** I'm grateful to the committee for this opportunity to present my views to you today. I'd like to add my voice to the chorus of praise that's been given to the provincial government for tabling this bill, to the opposition parties for the warm reception they've given the bill at first and second reading, and certainly credit is due this committee for its ongoing efforts to consider the views of the public and hopefully improve this bill in any way possible.

I'm a general practitioner employed by the Barrie Community Health Centre. Perhaps some of you are familiar with CHCs. We have a special mandate that emphasizes health promotion and illness prevention. As well, we try to selectively target those patients from disadvantaged groups, generally lower-income, and other so-called marginalized groups that traditionally have received a lesser standard of health care than other citizens here in Ontario.

As such, I maybe have some different experiences as a health centre physician compared to other primary care physicians. I thought maybe it would be of interest to the committee to hear a CHC perspective on tobacco issues. In particular, I wanted to describe some of the negative effects of tobacco that I see with some of our poorest patients in the practice.

As well, I am appalled by the recent developments in Ottawa concerning the cigarette tax rollback, and although I offer no expertise in law enforcement, I felt strongly enough about it that I wanted to use this occasion to offer some opinions about how I thought Bill 119 may counter some of the negative effects the tax rollback may have here in Ontario.

By now the committee has heard all kinds of testimony



from other doctors and public officials on the devastating health effects of tobacco. You've just seen it very graphically demonstrated 10 minutes ago. As a family doctor, I can certainly add my own tragic vignettes to the accounts you've already heard: the severely asthmatic child whose parents won't quit smoking, the young man left without a tongue after a cancer operation, the elderly woman who is completely oxygen-dependent and can't leave her home for the rest of her life; as well, the many deathbeds I've stood helplessly by. Rather than relate these in detail, I thought instead I would emphasize some of the more subtle but equally tragic ways that I see tobacco affecting some of my poorer patients.

As mentioned, CHCs tend to selectively target disadvantaged groups. In our own CHC, for instance, we see street youth, people in social housing, people with mental illnesses trying to live out in the community and a lot of lower-income families just from the surrounding neighbourhood. It's well established that lower-income groups have much higher rates of tobacco use. We know that this is true of our patients from a 1990 survey which showed a smoking rate of 37% among the low-income households, but only 23% in households earning \$50,000 or more. In other words, the poor smoke at approximately twice the rate of wealthier Ontarians, and that's particularly true in our area.

It is also well known that the higher smoking incidence among the poor is a contributing factor to their higher rates of morbidity and lower life expectancy compared to higher income groups. I refer to a study that was done in Alameda county to support that.

We commonly see patients who complain that they can't afford to eat nutritiously or live in decent housing but who think nothing of spending \$4,000 a year on smokes. The harmful health effects of nicotine are, for these people, compounded by the effects of a poor diet, poor clothing, poor housing and a lack of transportation, which increases their exposure to bad weather. While tobacco can't be blamed for all their woes, the income that is so casually squandered on cigarettes would make quite a difference in most of these lives.

Nobody suffers more than their children. The link between low birth weight and low income is largely explained by the above factors, with tobacco use figuring quite prominently. Thus, a lot of these kids enter the world with a strike already against them. As infants and children, they're exposed to secondhand smoke and hence are more likely to acquire respiratory problems. It's clear from the patients we see that many parents will unfortunately compromise their kids' clothing, food and shelter to help pay for their tobacco habit, so it's little wonder that the kids are constantly sick and absent from school.

By the time these children reach their teens, they are far more likely to smoke than other kids because of self-esteem issues and also their parents' role modelling of tobacco use. Thus, the cycle of poverty and ill health threatens to continue on to the next generation.

Counselling these people to quit is generally quite futile; I'm unsuccessful probably 90% of the time. The addiction itself is of course a very powerful one, but there are other factors too which defeat cessation efforts.

For instance, popular social gathering places are veritable temples of tobacco use: the bingo halls, the legions, the clubs and taverns. One's smoking habit is constantly reinforced in these settings, making it unlikely that you will ever be motivated to quit or that you will get the support and the validation you need if you're attempting to quit.

Also, with less disposable income it's more difficult to pursue other recreational interests to cope with the psychological needs that smoking appears to fulfil. Health professionals are essentially powerless to deal with these kinds of environmental obstacles.

#### 1450

There are other health and economic effects of tobacco use that we, as physicians, see but don't as readily recognize. For instance, employees who smoke are much more likely than non-smokers to be absent from work for health reasons. I've cited the Whitehall study of British civil servants to give you some statistics on that. These are mostly the smokers we see in practice who, in their 40s and 50s, come to us with prolonged lung infections complicated by pneumonia and bronchiectasis, needing a medical excuse for work or perhaps insurance forms completed for disability.

The Whitehall study had previously shown that employees who smoke were more likely than non-smokers to die or otherwise leave the labour force prematurely due to illness. These are the smokers we see in their 50s and early 60s who have had heart attacks, angina, claudication, strokes or lung disease, who need their disability pensions before they've really been able to properly retire. While these are less dramatic than the mortality statistics that are often quoted, they include some of the hidden costs which are not often included with the other direct health care costs of tobacco use when we're trying to estimate its impact on society.

I realize that nobody on the committee is likely at this point in the proceedings to really need further convincing that tobacco is a terrible health and social menace. What is at all controversial about the bill are those proposals such as the ban on tobacco sales in pharmacies that may conceivably result in job loss.

I believe that the committee must not be distracted from the fact that what it is dealing with is essentially a moral issue. We would agree, I think, that it would be wrong to murder someone for their money. It doesn't matter how much money they have, how badly we might need it or what wonderful things we might be able to do with it. We are compelled as a moral society to place greater value on human life than on any economic or monetary gain that might be made by taking that life.

I would challenge members of the committee to tell me in what substantial way the issue of job loss through the restriction of tobacco sales is different from this simple moral position. No, we're not talking about murdering people outright, but they are gradually being poisoned to death over 40 or 50 years; in the end, they're just as dead. Of course, we're not talking about one life but the lives of 13,000 Ontarians every year into the foreseeable future. People must come before profit. Health must not be sacrificed for wealth.

I'd like to use my remaining time to offer some opinions on the smuggling issue. Last week, the Canadian health community was devastated to learn of Ottawa's decision to roll back the federal tax on cigarettes. It is to the great credit of the Ontario government that it has so far refused to comply with tobacco tax reductions. Unfortunately, if both Ottawa and Ontario maintain their present positions, it will predictably lead to increased smuggling into Ontario from the United States. Ontario basically has three choices: It can do nothing and allow smuggling to increase; it can abandon the moral high ground and capitulate to Ottawa's ill-advised policies; it can seize the opportunity afforded by Bill 119 to legislate tough measures that will counteract smuggling without further sacrificing the lives and health of Ontarians.

There are several provisions that are currently proposed for Bill 119 which I believe will help curb smuggling. Prohibiting the sale of tobacco in designated places, including hospitals, nursing homes and pharmacies, as well as banning vending machines will reduce the number of retail outlets substantially. There would be a lot less ground for provincial health inspectors to cover, and one would expect this to increase the effectiveness of enforcement measures.

Bill 119 also seeks to further regulate packaging, including the nature of health warnings appearing on packages. Plain packaging and prominently featured health warnings should make it easy to distinguish cigarettes sold in Ontario from products sold outside the province and therefore should help to expose contraband.

Lastly, Bill 119 proposes to establish new penalties, including fines and sales prohibitions, on retailers caught violating its terms. These would hopefully be a lot more severe than the slap on the wrist currently given to people involved in illegal tobacco trade and should be much more of a deterrent, especially for selling to minors.

In addition to the provisions already suggested for Bill 119, I feel there are several ways it could be toughened to further combat smuggling. Bill 119 could be amended to call for the licensing of tobacco retailers. This could generate additional revenue for the government to help beef up its enforcement. With licensing would presumably come some kind of review process to make sure retailers understand and are complying with tobacco control measures before licences are granted or renewed.

This ought to make it more likely that those breaking the law are exposed and penalized. The threat of revoking a licence has been shown in other jurisdictions to be a powerful motivator for retailers not to sell to minors. I refer you to one study from the Journal of the American Medical Association. It stands to reason that if you know that the licensed retailers are on side with the law and yet minors are continuing to smoke, this would help expose illegal tobacco trade. With a licensing system would hopefully also come additional sanctions for selling tobacco without a licence, which could be additional legal leverage to use against the pushers of contraband.

In addition to penalizing retailers and pushers, I believe that Bill 119 needs to place some onus on underage smokers to comply with the law. Perhaps any minor caught purchasing tobacco or even caught smoking

in a public place could be fined and have his cigarettes confiscated. Anyone assisting in the provision of tobacco to a minor could be similarly fined, whether or not a licensed retailer. The police or other officials could exercise the right to question offenders as to their source of supply, and maybe the size of the fine could be based on their willingness to share this information.

If Bill 119 is passed intact or with tough amendments, the effect should be to decrease the demand for tobacco over time, and hence the profitability of illegal trade. Ontario could present a strong example of the political resolve necessary to take on the tobacco industry, most notably to the United States, which is also presently looking at stricter tobacco controls and which could well end up solving our smuggling problems for us.

This concludes my presentation. I've provided just a small appendix to substantiate some of my positions. I just want to add that I feel the work you're doing is of the utmost importance and that I and the health community anxiously await the product of your combined wisdom. I'd welcome any questions.

**The Chair:** Thank you. We really do appreciate this particular perspective, which is not one that we have had, coming from a community health centre.

**Mrs Cunningham:** Welcome to the committee. You had a predecessor from your community last week representing the Ontario College of Family Physicians, Dr Brian Morris, who made an outstanding presentation.

I'm interested in the fairly strong opinion that you've taken on this whole issue of licensing. We're hearing it more and more. I'm also interested in perhaps some kind of penalty for the young person who purchases the cigarettes. Maybe we heard it before, but I heard it first from a medical officer of health from Windsor and Essex when we had the hearings in London.

We've had some opposition to it. I think, quite frankly, that the administration didn't recommend licensing to the government because they thought it was somewhat cumbersome, but as time goes on, we're getting our questions answered. Perhaps you could just explain how you think this would work, and also what your opinion or ideas would be around some kind of a sanction for the young person under the age of 19.

**Dr Gaspar:** For your first question about licensing, we do have research. I mentioned the one article from the Journal of the American Medical Association. In this particular article they demonstrated that within a year and a half of licensing retailers, and through strict enforcement, they were able to cut down on the amount of sales to minors by 50%. So we have evidence that a licensing system is extremely effective, okay?

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I know it hasn't been proposed by this administration. If licensing doesn't go through with this bill, perhaps there could be some kind of compromise where, say, the chief medical officer of health would review the situation in 12 or 18 months and advise the government further as to the success of the proposed fines and prohibitions that are currently in the bill.

As to sanctioning minors, I think it's clear that most



minors who smoke are well aware that they're breaking the law and this is some of the allure of underage smoking, sort of the James Dean mentality that, "I'm a rebel and I'm breaking the law and I don't care who knows it." I don't think it's out of line for the government to expect minors to pay a price for that kind of attitude. It encourages maybe a certain cynicism towards the law from a very early age that could conceivably lead to other forms of lawbreaking later on, maybe underage drinking or reckless driving. Who knows?

I think it's well within the government's right, if it feels this kind of measure's enforceable, to specify some kind of sanction like that.

**Mrs Cunningham:** We had community work. I just wanted to add that so Dr Gaspar would know that everybody didn't think money was the answer; a lot thought that some community involvement might be helpful.

**Mr McGuinty:** Thank you, Dr Gaspar. I too appreciated your comments about the advisability of putting in place some kind of mechanism which would fine young people or help bring home to them that there's something fundamentally wrong with this. The example I'd like to use is that if you've got a couple of kids sitting on the curb, one drinking beer, the other smoking, the police officer can confiscate the beer and charge the child drinking it, but he cannot confiscate the cigarettes from the other one and he cannot fine him, notwithstanding that we've heard all kinds of evidence over the past three weeks that tobacco-related illnesses far outweigh, in terms of their severity and their numbers, the effects of alcohol.

The other thing that I really have found very helpful was your bringing home to us the direct link between the lower socioeconomic groups and the higher rates of tobacco use. I'm not sure if we've had that evidence yet. I can't recall, anyway, somebody bringing it before the committee. I guess it's not politically correct, but in the old days we called them poor people. For a child growing up in poverty, the chances are that one or both parents are smoking. They've got a couple of strikes against them already. What is it we can do that we're not doing right now? Is there any hope for that child?

**Dr Gaspar:** Unfortunately, the negative role modelling of the parents is probably one of the greatest influences in these kids' lives. I believe a tough and consistent approach from government, following through with some of the sanctions that are in the bill and that I've discussed today, would probably have more of an impact than practitioners like myself providing counselling. As I mentioned, I'm a pretty abysmal failure as a counsellor, as are most doctors. I don't take a very high view of what I'm able to accomplish or what other public health initiatives are able to accomplish.

**The Chair:** Thank you very much for coming down from Barrie and appearing before the committee.

I'm going to ask Bob Gardner to note a couple of things that have been distributed. Bob, do you want to report on some of the material you've distributed to us?

**Mr Bob Gardner:** Thank you. I just wanted to show

the pile of things we've given members today. It's easy to lose them in all the other briefs and so on.

First of all, the second summary: This is from last week, so up until the end of last week. Then a couple of memos, one that Mr Wilson raised for the committee, the criteria for establishing a pharmacy in Ontario; another issue that Mr McGuinty asked for, background information on the federal legislation and the court challenges to it; and just to be perfectly non-partisan, we have something coming later on that Ms Haslam raised, an article that a witness in Thunder Bay wanted us to get from the Canadian Medical Association Journal.

**Mrs Haslam:** Oh, you found it?

**Mr Gardner:** We did. Librarians particularly like the challenge of finding articles without authors and—

**Mr Wiseman:** Without titles.

**Mr Gardner:** No, we had a title. We had the wrong decade, I will point out, but anyway.

**Mrs Haslam:** Please convey to the library my congratulations and my thanks, because I know how hard librarians work and this is really something.

**Mr Gardner:** I certainly will, Ms Haslam. Thank you. Then there are two sets of press clippings, one from over the weekend and one from today.

**Mr O'Connor:** I will ask the clerk to circulate this cartoon from the Globe and Mail today that talked about what our friend from Barrie just presented to us about the illegal cigarettes, smuggled cigarettes, and the federal government's approach to it.

#### CANADIAN PHYSICIANS CONCERNED ABOUT SMOKELESS TOBACCO

**The Chair:** Gentlemen, we welcome you both to the committee. I understand, Dr Connolly, that you have come a somewhat longer distance than some of our witnesses and we appreciate that. I'll leave it to both of you how you wish to proceed with the presentation.

**Dr Jack Micay:** I'm going to begin. My name is Dr Jack Micay. I'm a family physician in Toronto and I'm actually here for the second time, so I beg your indulgence. I'm representing a group of physicians who are concerned about a form of tobacco use that's not included in this legislation and that's what this presentation is on. Although my particular group is a small one, I think it's fair to say that we represent the general opinion of the medical profession.

Cigarettes now pose our largest public health problem. This is a product that kills 13,000 Ontarians a year when used as intended, is at least as addictive, if not more, than cocaine or heroin, which is primarily pitched to young people, and which has no nutritional or other benefit. If today such a product were introduced to the market, surely it would be stopped, it would be banned, it would not be allowed on the market.

Unfortunately, it's too late to ban cigarettes. Far too many people are addicted to them and it would be as futile to ban this product now as it was to ban alcohol during Prohibition.

However, there is another group of tobacco-based products that are equally addictive and cause serious

health problems including lethal cancers again when used exactly as intended, and my colleague Dr Connolly will detail this further in his presentation. Some of the data's included in our fact sheet and I won't go over it right now. These products are also pitched to young people and they also have no redeeming value.

This is smokeless tobacco, otherwise known as spitting or chewing tobacco. The only good news about these products is that they are not yet widespread, and it's possible to avoid the mistake that was made with cigarettes and to get rid of them now before it is too late.

Smokeless tobacco is divided into chewing or plug tobacco, such as this package I'm holding of Redman, and snuff, such as this package of Skoal Bandits, which includes dry and moist snuff and fine-cut tobacco, all of which are held between the gum and cheek. Fortunately, their use is not nearly as widespread here as in the US, where they are used by a large and rapidly increasing segment of the teenaged population, as Dr Connolly will no doubt report. However, I was able to buy these products this morning at the very first convenience store I went into.

Over 99% of all the smokeless tobacco products sold in Canada are imported, mostly from the US. As I mentioned, right now usage of these products in Ontario is low. However, there is every reason to believe that if we do nothing, the use of smokeless tobacco among Ontario youth, particularly boys, will increase as it has in the US.

For one, they are a cheaper form of nicotine than cigarettes, even at low US prices. What is more, in the US they are being targeted to young teenagers. In fact, US surveys have shown that the age of initiation for these products is even lower than it is for cigarettes. A case in point is this product, Skoal Bandits, which is a low-nicotine brand that is aimed at the 10- to 13-year-old as a sort of starter kit. It has a low nicotine content which they are better able to tolerate than stronger brands of snuff or chewing tobacco.

In the US again, smokeless tobacco is heavily promoted and these products are endorsed by professional athletes, lately racing-car drivers. Here in Canada, kids are exposed to many of these same promotions through television, magazines and to the local major league baseball players who can be seen chewing tobacco on television. Not only do kids begin using this product at a younger age than they do cigarettes, they are sadly misinformed about it.

#### 1510

A survey of teenagers by the Red Deer, Alberta, regional health unit revealed that kids are under the illusion that smokeless tobacco is less addictive than cigarettes and that it is a safe alternative and an aid to quitting cigarettes. By coincidence, on the Rush Limbaugh television show which was aired on CFTO last night, there was an advertisement for a brand of chewing tobacco called Quit, which indicates a new marketing strategy for chewing tobacco as an aid to quitting cigarettes.

In fact, surveys have shown that smokeless tobacco is

actually a gateway to cigarettes rather than a way to avoid cigarettes, and the majority of kids who use it eventually add in cigarettes or switch over completely to cigarettes. It's a great way for the tobacco industry to introduce kids to nicotine addiction and at the same time to increase their future cigarette sales.

Now that the price of cigarettes has been dramatically and tragically reduced in Quebec and less so in Ontario, tobacco product use, with its resulting addiction, death and disease, will soon be increased equally dramatically among young Ontarians. It's known that in the US one of the gateways to cigarette smoking is smokeless tobacco, as I mentioned. Dr Connolly will also perhaps provide evidence of how a majority of kids who use smokeless tobacco eventually switch over to smoking cigarettes to maintain their addiction.

Bill 119 is intended to "prevent the provision of tobacco to young persons." It's a very timely piece of legislation that can help to offset the lower price of cigarettes and to protect the young people of Ontario from this deadly product. However, in order to do so, certain provisions must be added and others strengthened.

In the first category is a ban on all smokeless tobacco products. It will remove a tobacco product that is deadly in itself and which is particularly aimed at very young teenagers. It will also remove a product that the tobacco industry uses as a recruiting tool for cigarettes and as a fallback product for those smokers who wish to quit but cannot break their nicotine addiction. There will never be an easier time to remove this pernicious product than right now.

Smokeless tobacco now occupies less than 2% of the total tobacco sales market, and as surveys by the Addiction Research Foundation have shown, most of these sales in Ontario are illegal ones to minors. Many other jurisdictions have banned smokeless tobacco, as detailed in our fact sheet. There is no reason why Ontario should not add its name to this list of honour.

Banning smokeless tobacco is an easy and effective way of reducing access to tobacco products by young people, but it is not enough in itself. We believe that other steps to reduce access are also important, particularly banning the sale of cigarettes in pharmacies to reduce the number of outlets, but more importantly to remove this implied endorsement of cigarettes by the health profession of pharmacy which undermines all the anti-smoking messages from the government and the health community.

Another provision that in my opinion should be added to the bill to counter the allure of cheap cigarettes is to mandate generic packaging. This will remove an important marketing tool from the cigarette industry and it will break the link between their tobacco brand promotion, much of which is aimed at young people in the form of sports and fashion events, and the product itself.

I'd now like to introduce Dr Greg Connolly who, as mentioned, has come here especially from Boston for this presentation.

Dr Connolly is a world expert on smokeless tobacco. In Boston, he's the director of both the Massachusetts



tobacco control program and the Massachusetts dental health program. He's a graduate of the Tufts dental school and the Harvard school of public health and a consultant to the United States National Cancer Institute on oral cancer associated with smokeless tobacco use.

He has published widely on the connection between smokeless tobacco and oral health. He's also the chairman of the World Health Organization study group on smokeless tobacco and a consultant on this issue to the health departments of many countries.

Last but not least, he's an adviser on this issue to major league baseball and has lectured about it to the Toronto Blue Jays, he tells me, on three occasions. I'll hand it over to Dr Connolly.

**The Chair:** What success had you on those three occasions? We'll check Pat Borders out in the—

**Dr Gregory Connolly:** I'm going to show in a few minutes a young man I brought with me to spring training this year. By happenstance, the Phillies were playing the Blue Jays on opening day and we brought the Surgeon General down. I think we pleaded not enough to the Phillies, if you looked at the fifth game of this year's World Series. We were more successful with the Blue Jays.

I'm pleased to be here. I want to report that Toronto's closer to Boston than Washington, DC. I testified before the House ways and means committee in Congress a few weeks ago on the Clinton tax package to raise the cigarette tax \$1, and the only members who remained in the committee were from the grand states of North Carolina, Virginia and Kentucky, and that was one tough hearing. I hope this is a nicer hearing here in Canada.

**Mr Wiseman:** We all agree that cigarette smoking and tobacco are bad for you.

**Dr Connolly:** I also say that my grandmother was from a nice farm in Deseronto and my grand uncle was an Ontario physician who invented the voice box, Dr Hainey, at the beginning of this century. So I find my roots in health probably are more here in Ontario than with my relatives in Boston.

**The Chair:** Welcome back.

**Dr Connolly:** Thank you. I reproduced a fact sheet here talking about the problem with smokeless tobacco. I'd like the committee to consider that these products are really new tobacco products. This is where an industry, when losing its consumers for cigarettes, has used high technology, particularly for the oral snuff, to design a nicotine delivery system to recruit either smokers who quit or young people who haven't started tobacco use.

The nicotine content in this has been scientifically reduced to a level where you don't develop toxic effects such as gastric distress or harm to the nervous system. So the user can gradually develop dependence on the product over time. This is not a traditional tobacco product. This is really using high technology to introduce new products into a marketplace over time to replace people who quit or keep people using tobacco products.

To think of this as something that's been around for 100 years is really fallacious. When we grandfathered cigarettes into use into North America at the beginning of

this century, we really grandfathered in something that's far different than what we see today: cigarettes with all the additives, with nicotine being sprayed on. We really need a format for regulating the introduction of new products, particularly those that appeal to young people.

I've brought a few slides with me. Could we just flip that on? This is an advertisement for smokeless tobacco. It's Skoal Bandit. This is where the nicotine yield has been lowered to about four milligrams per gram. As part of a graduation strategy, the industry had a clear strategy. This is snuff in starter wheels. This is heavily advertised and promoted, with free sampling. On the other page, you see a coupon for a free sample. They had a college marketing program on 200 college campuses.

Part of the program called for a graduation strategy. In this ad here, it tells them how to use it. "How long should I put the Skoal Bandit in my mouth?" It says: "The first time, just for about a minute, then remove it. The next time, leave it in a little bit longer, just like your first beer."

Finally, the graduation strategy moves users up to this brand, Copenhagen, where the logo says clearly, "Sooner or later, it's Copenhagen." There's four times the amount of nicotine in this product.

Research at West Point shows the cadets, the plebes, started with the Skoal Bandits and they graduated to Copenhagen by senior year. My research with major league baseball finds that by the time they're professional baseball athletes, they're using Copenhagen primarily. They started off in high school and college using the Bandit, but they're hooked on Copenhagen. My research, including an article published in the New England Journal of Medicine that included the Blue Jays, found that 60% of the athletes wished they had never started; 50% reported sores in their mouths; 60% reported trying quitting during the past year but they relapsed. They're highly addicted to this product.

This product also delivers about three times the amount of nicotine in a pack of cigarettes. It's a very cheap source of nicotine. If you're faced with buying three packs of Marlboro or a can of Copenhagen, you're going to buy the Copenhagen. You're going to save money because of the high nicotine yield. It's particularly true in Canada, where your taxes for cigarettes are high. For young individuals who have limited disposable income, these products become popular.

Use in the United States has soared. This is for moist snuff only. We've gone from 23 million pounds to 40 million; today's number is about 55 million pounds. That represents about a billion tins in the United States of America, compared to we estimate that in Ontario it's about 2 million to 4 million tins. You really don't have a problem right now. In the United States, we've got a very serious problem with use of this product.

1520

Who are the new users? This is a kid in Brookline, Massachusetts. We didn't have use; we discovered use in 1984. We failed to act as a state. Now we're finding that in our male cohorts, 18 to 25, we have high use rates. For us to look at a prohibition is extremely difficult now,

given the fact that these individuals are over the age of 18. But the new use rates have soared among high school kids, and it sort of spreads. Where the captain of a baseball or football team will move from one high school to the next, it becomes widespread.

These products are also easier to use than cigarettes. The age of initiation is about age 10. You don't have to inhale. A 10-year-old's lung is not going to tolerate tobacco smoke that well, but you can place it in your mouth. If smoking's been banned within the high school campus, this product can be discretely used. Teachers won't smell tobacco breath and one can quietly spit the tobacco product.

Following this marketing campaign, in 1970, highest use rates were among males over age 50; by 1985, it was males between 16 and 19. Now the upper slide, we're not concerned with that. The old gentlemen will probably die with their tobacco and save on our social security fund. We are concerned with the bottom chart, because that's a ticking time bomb in the mouth of youngsters.

Smokeless tobacco does produce nicotine addiction, believe me, with baseball players. Borders has tried to quit. I worked with Kelly Gruber five years ago, although I know we don't want to talk about Kelly Gruber today. But he reported a red lesion on his tongue. He was very concerned. He quit. He stayed tobacco-free for about four years, and all he had to do was have a touch of it and he slipped back again, although he's using a lower-nicotine brand. It does produce powerful nicotine dependence, at blood nicotine levels equivalent to that of smoking, although they'll use about a third of a can a day compared to about a pack of cigarettes.

What do we see? This is a common, garden variety gum recession. The nicotine, the alkaloid, burns the gum tissue. The irritation of the tobacco cuts it and results in destruction of the periodontium, the bone. This is a grade 3 lesion. This individual could lose that tooth over time, and it's very expensive to treat. We're talking a large amount of money. This is another young man, a West Point cadet I treated, who began using it as a freshman, a plebe, and he lost that tooth just about four years later. This is fairly frequent.

I would have fun playing with baseball players and the game is, "I can guess how many cans you dip a week." They said, "You never can guess." I think it was the Blue Jays I tell this story about. I looked at one athlete—I don't want to share names—and I pointed and I said, "A can a week," and he said, "I beat you, Doc." I said, "Well, let me look over here." So I looked in this side of the mouth. I said, "A can there and a can over here." He said, "How did you know?" Three cans.

You can see the lesions in the mouth, and this is what you see. This is about one can a week. It's a leukoplakia. It's a patch. The body's trying to protect itself with a slight irritation. This is about a can and a half a day. This is a major league player using the product. You see a very severe white lesion with furrowing. Now, if you biopsy those, anywhere from 3% to 6% are going to show dysplasia, that is, an indication of going on to cancer, and in research done by the University of San Francisco in the Cactus league of 98 lesions biopsied,

three were actually precancerous lesions pointing towards cancer. I'm going to show you in a few minutes a video I took of a baseball player who suffered from this disease.

This is an erythroleukoplakia. This is where the white lesion breaks down and the body's protection is lost. This is a very vicious lesion. These lesions will progress very rapidly and contribute to oral cancer.

The compounds we're concerned with: Smokeless tobacco in any tobacco plant contains a number of carcinogens. You have arsenic, formaldehyde is in the product, you have cadmium, but the potent carcinogens include a class of compounds called nitrosamines.

Nitrosamines are species- and site-specific. There are four nitrosamines. When you feed them to animals, you will get brain tumours in rats. If you inject it in a hamster, you'll get a lung tumour. It appears that for the animal species, when you place the nitrosamines on the oral mucous membranes, you produce cancer of the oral mucous membranes at exposures that would be equivalent to what you need to produce a cancer in a laboratory animal.

Generally, for any consumer product, we would like to set tolerance limits at about 1/10,000th of the dose received by the consumer product. This country also regulates nitrosamines in beer. We've set a limit of five parts per billion; bacon, five; baby bottle nipples, 10. For these products that are unregulated, the concentrations range from 1,000 to 10,000 times greater than what you'd receive in any regulated consumer product. There are more nitrosamines in this product than would be in a truckload of bacon outside this building.

Again, this is a new product. This is not something that all of a sudden people are going out and growing in their backyards. This is being produced by good science with high technology, without a regard, though, for the damage to human health or human life.

This is a verrucous carcinoma, a slow, wart-growing lesion. This is probably a good lesion because it's not going to metastasize. It can be taken out of the mouth and we would look at good remission.

This is a young man from Texas, 28 years old, who consumed smokeless tobacco rather heavily. He has what we classify as a site-specific lesion; that is, the squamous cell carcinoma perforated the lower lip. He unfortunately went through a series of cancer treatments and it metastasized throughout his body. He subsequently lost a portion of his face and died in two years from metastases. These lesions are very, very aggressive lesions. There are time bombs ticking in the mouths of young people. The industry, as we make progress with cigarettes, is only bringing in new products to maintain its profitability.

For Canada, it's a particular concern because I've looked at data for the past few days when I was asked to testify. If you look at use among adults right now, nationally it's about 0.7% using chewing tobacco, about 0.4% snuff. It's virtually an unknown practice; it's less than 1% of the adult population. However, among school-aged children in Ontario, among the males, grades 7 to



13, use rates according to a survey done by the Addiction Research Foundation of Toronto report 3% of males currently use spitting or smokeless tobacco only and an additional 10% both use smokeless tobacco and smoke cigarettes, for an alarming rate of 13%. Primarily, if you look at those numbers, the sales are going to children.

What's happened internationally? I had the distinct pleasure of chairing the World Health Organization study group in 1988. We had representatives throughout the world on that panel. We reviewed the scientific evidence and I'm going to leave for the committee the report of WHO on smokeless tobacco. We recommended, based upon the experience in the United States and the Scandinavian nations, that nations without a history of use ban this product before use becomes widespread among young people.

I'm pleased to report that following that recommendation the governments of Hong Kong, New Zealand, Australia, Ireland, Great Britain and Belgium banned the product. I'm pleased to report that following the Irish ban, which was challenged by the tobacco industry in the High Court of Ireland, as well as a challenge on the Treaty of Rome, the European Parliament banned oral snuff throughout the European Community. The only developed nations in the world today that allow the sale of this product are the United States of America and Canada, as well as the Nordic nations. Action by this body here would set a very important precedent for North America in particular.

I'd also say that in the United States, the United States has banned new forms of tobacco. The United States Food and Drug Administration banned a chewing gum with tobacco called Masterpiece in 1988. The United States of America Food and Drug Administration banned Favor cigarette, which was a look-alike cigarette with a nicotine inhaler. The states of Colorado and Missouri banned the R.J. Reynolds Premier cigarette before it was introduced. There's clear international precedent for treating this product the way you treat any other product.

I'd like to end, if I may, by showing a three-minute video that I brought of a young man who spoke to the Blue Jays this past year and I think had an impact. This man started using smokeless tobacco at age 8 in Texas. Could I have the video please?

**The Chair:** The parliamentary assistant had a clarification. Maybe we could just deal with that.

**Mr O'Connor:** Thank you for your presentation and coming up here and discussing and adding your valuable expertise to this. I don't think we're at the point right now where we have completed things, so we have time for some input and some changes. If we were to try to encompass everything you're asking us to encompass, are there certain names of tobacco products we should be including that would then perhaps not allow somebody to undermine the intent of a ban, if we were to move in that direction?

**Dr Connolly:** We could provide the committee with the European Community's definition of smokeless tobacco: chewing tobacco and oral snuff. There was some discussion within the European Community about not encompassing nasal snuff that was for traditional use. We

could provide the committee with a clear definition other nations have developed in their policies.

**Mr O'Connor:** Thank you.

**The Chair:** Would you just tell us about the snuff, which I always had thought was nasal but I see clearly is also something you put in your mouth. How is that determined, these different kinds of tobacco? What do those words mean?

**Dr Connolly:** Moist oral snuff is a finely ground tobacco that's fermented, and the fermentation process unfortunately creates this witches' brew of carcinogens. That is the product that's being marketed heavily. That is the product that's being used by young people.

With nasal snuff, you still see a tradition of use among the very old. In Britain, there are some snuffers, and some in southern France. Those products have not been banned because of use by old people. The policy is just to let the old people die. It's truly the moist oral snuff, the high-tech nicotine delivery devices, that we're trying to encompass in a regulatory schema.

**The Chair:** Thank you. I think now we're all set.

*Video presentation.*

1533

**Dr Connolly:** That man began before he could legally purchase, became addicted, and it's a situation where he just couldn't stop despite known effects. I brought this individual down to major league ball and he talked to the players here in Toronto. These people are highly addicted. This individual couldn't motivate them to quit because of the power of nicotine addiction. If we can prevent children from becoming addicted to these products, then it makes very reasonable, rational policy for government to do so.

**Mr Wiseman:** How old is he?

**Dr Connolly:** He's 28.

**The Chair:** Dr Connolly, thank you very much. While we have gone a bit over time, given the fact that we haven't looked at this issue other than briefly yesterday, I think there may be some questions and we'll try to deal with this now.

**Mr McGuinty:** Thank you both, gentlemen, and a particular thanks to you, Dr Connolly, for taking the time out to come and speak to us here in Toronto today. You've made a very important presentation. We have been learning about and experiencing the frustration associated with trying to control a legal product which has developed over a lengthy period of time, on a road over which we've travelled a great distance.

The import of your presentation today is that this is a new road that's just opening up before us, which comes with smokeless tobacco, and we have an opportunity we didn't have before to properly address this. I haven't had a great deal of time to think about it and I didn't really put it in that context before you made that argument. I think it's a very powerful argument.

I want to ask you about the ban in other countries. Has there also been a prohibition on possession? I'm worried about it coming in from Quebec or from the States. What have they done in those other countries?

**Dr Connolly:** It varies from country to country. In the European Community, it's a ban on sale, not on possession, because of the number of Scandinavians who would go through the European Community. So it's sale and manufacture, not possession. In Australia, again it's sale and manufacture. I believe it was possession in Australia, but by and large the bans have been on manufacture and sale.

I'd point out too that this is a legal product for persons 18 and over, but in a population where the primary use rate is among people below 18, then it's really trade in an illegal product. You have to put it in perspective. In the other countries it is not a problem because, like Canada, they don't have use rates. They've really intervened before they have use rates.

**Mrs Cunningham:** Thank you both very much for being here. I think that as the hearings proceed people are becoming more daring in the recommendations they're making to this committee, based on the kind of evidence you've presented today. I think one of the great problems we face as legislators is that we're not as well informed as we could be, but we're finding that at the end of hearings on almost anything, we're much better informed and the problem seems to be getting out to the public with regard to education. But there's a lot of impatience around this committee, because we've been part of education programs in our former lives as members of lung associations and heart and stroke foundations and all those things for maybe 20 years. There's a bit of impatience with this group, I detect.

I just have to say that personally, I'd just ban it. That would be my vote. It's that simple.

1540

I am interested in the point you made about banning the manufacturing, which I think is something we're going to have to have some advice on, Mr Chairman. If we decide to go in that direction, we're going to need some research, because we need to know what to ban.

Secondly, banning the sale is something we're looking at in this bill in a sense, because we've got larger fines, but we've been looking at three other alternatives: One is to license the person who is doing the sale, the retail salesperson. Two is to look at moving all these products, if we don't make them illegal, into outlets which we already have in Ontario for alcohol, the LCBO; they're right out of the public place altogether. We're very concerned about bureaucracy here, but we already have a system in place that you don't have in most of your states. The third one, of course, is to look at fining or penalizing in some way the young person under the age of 19. If you can respond to some of the other alternatives, based on your experience, we'd appreciate it.

**Dr Connolly:** I make two points. I don't think the alternatives are mutually exclusive. I don't think you can only do one. The point in Canada is that if you look at your own data on smokeless tobacco manufacture, it's probably fallen from about 500 million tons 15 or 20 years ago to less than two million tons. Primarily what you see here is two US manufacturers manufacturing a product in the US and exporting it here and then taking back the proceeds minus taxes and retail markup, so the

manufacturer is really not an issue.

What we're saying is that for the new class of tobacco products that are going to be brought into society, we need some sort of policy framework to deal with their introduction. Maybe in lieu of a ban, you could say, "Yes, you can sell new nicotine delivery devices, so long as they're done in a policy framework where nicotine is used to help people quit their dependence." Maybe you could develop a sachet of tobacco minus the carcinogens or set tolerance limits to help people quit tobacco use, to help smokers stop smoking. That would be an alternative to a total ban.

**Mrs Cunningham:** Is that something the product you just held up is used for, to help people quit?

**Dr Connolly:** No. It's promoted as a temporary alternative where you can't smoke—at least there have been marketing campaigns among adults—and it hasn't been successful. In essence it keeps you on cigarette smoking, because it's highly flavoured and it's sweet. It's not designed like nicotine chewing gum that's really hard to use: You don't want to stay on it that long. You want to break the habit. This is sort of the reverse of it. One ad was, "Take a pouch when you can't take a puff." You see it in airports. It keeps people smoking. This is a way to keep you addicted to nicotine.

If you said to the manufacturer, "Reduce the cancer-causing levels," and you probably could do it to an extent, you couldn't eliminate it—

**Mrs Cunningham:** I see what you're getting at.

**Dr Connolly:** —and make it so it helps you quit, what they would say to you is: "No business. We're not going to put ourselves out of business."

In the United States, the Food and Drug Administration asked the manufacturer of a chewing gum with tobacco—it was the lady's equivalent of this product—to come in and say why it was good to ingest tobacco, what the beneficial good was, and the manufacturer then took it from the marketplace when asked to prove that.

In the United States, we have the R.J. Reynolds Tobacco Co manufacturing nicotine inhaler—it's called Premier cigarettes—to keep people smoking when they're banned from the marketplace. Our Food and Drug Administration in Washington didn't take action, but two states did. They banned the product, and then the R.J. Reynolds Tobacco Co took it off the marketplace.

We're trying to develop a future policy so we don't repeat our historical mistakes, and the WHO recommendation is, if the only people who use it in your country are kids, ban it before the adults use it.

I think that's a reasonable public response. I don't think it's puritanical. I don't think it's extremist. What I see in that video is extremist. For a society to tolerate that among its young people is really not a reasonable, acceptable approach. Just look at this product and say it has 10,000 times the amount of nitrosamines of a can of beer or a baby bottle nipple. Treat it. Give it fair and equal treatment. It's a highly addictive product that's been designed to encourage young people to use it. Give it fair and equal treatment.

I don't think the ban is an extremist position. If you



look at what's happened in other parts of the world, other nations have looked at this issue. The vast majority of developed nations have made a reasonable public decision, and that is, control the new products.

**The Chair:** I regret I have to play the heavy as the Chair. We have gone a bit over our time in view of the nature of the presentation, not to mention the distance you've come. We want to thank you both, but Dr Connolly in particular, for what you've brought before us here this afternoon.

#### ARTS AND HEALTH ALLIANCE

**The Chair:** I call on Ms Valerie Hepburn, member of the steering committee of the Arts and Health Alliance. Introduce your colleague, who is also welcome.

**Ms Anne Bermonte:** I am Anne Bermonte and I'm on the steering committee of the Arts and Health Alliance.

**The Chair:** We have a copy of your written submission, so please go ahead.

**Ms Valerie Hepburn:** Good afternoon to you all. Thank you for allowing us this opportunity to speak to you about the concerns of the Arts and Health Alliance regarding the legislation at the heart of these current hearings.

To begin, the alliance would like to acknowledge the efforts of the Ontario government as well as the opposition parties in attacking head-on our most important public health challenge today: reducing tobacco use, particularly among young people. We acknowledge too that this challenge has taken on even greater magnitude in significance in light of recent federal tobacco policy.

Before I deal with the alliance's specific interest in Bill 119, I would like to tell you briefly what the Arts and Health Alliance is all about, and I hope you're burning with curiosity to know.

The Arts and Health Alliance, or AHA! as our brilliantly coloured acronym exclaims, grew out of a debate in Metropolitan Toronto over the issue of tobacco sponsorship of the arts. While in general there was a clear line between health and arts interests at that debate, let me be specific here that arts groups opposed a ban on tobacco sponsorship because they very much needed the funds that tobacco companies provided through sponsorship, whereas health groups opposed to that view supported a ban because they see and continue to see sponsorship of the arts as thinly veiled advertising by tobacco companies. However, many people on both sides came away from that debate feeling that some very important things had got lost, namely, those things which arts and health have in common.

Let me be specific. Arts groups care deeply about public health and they contribute to it every day, and here I'm not just talking about the more, shall we say, elite arts like opera and ballet, although they are wonderful and we know they are. Every time you buy a CD or go to a movie or attend a community theatre production or watch your child play in the school orchestra or in the school play, you are participating in the arts. The arts add immeasurably to our quality of life. Public health recognizes that the arts are fundamental to social, emotional,

creative and, yes, economic health.

The real issue at Metro and the real issue on tobacco sponsorship continues to be funding, and we thought there had to be a better way.

In 1992, the Arts and Health Alliance was formed to find that better way, to build on our common contribution to quality of life and to seek alternative funding sources that would first give arts groups the ability to choose not to take tobacco sponsorship—they do not have a choice right now; there is no meaningful alternative—and second, to give health groups the ability to tap the arts venues, so successfully used by tobacco companies essentially to advertise, to advertise messages about health.

A major goal of the alliance was and still is and will be to replace a tobacco culture with a health promotion culture, a goal we believe is particularly relevant to the young people who are the focus of Bill 119.

Today the alliance numbers over 70 supporters in Metro Toronto and other Ontario communities. They include health agencies and public health units, arts councils, performing arts groups in theatre, music and dance, literary and visual arts, film, arts education groups, elected officials and members of the general public, and we continue to grow rapidly.

Through several joint projects in 1993 and more planned for 1994, we've made a start in locating other funding, but we have a long way to go before we have a meaningful alternative to tobacco sponsorship, which brings me to Bill 119.

Clause 5(a) of the bill, which reads in part, and I quote, "No person shall sell...tobacco...or distribute it," and these are the vital words, "unless the tobacco is packaged in accordance with the regulations," allows the government the regulatory authority to introduce measures related to packaging. The Arts and Health Alliance is particularly interested in the possibility of plain packaging and its effect on the sponsorship issue.

We should be clear from the start that we do not oppose plain packaging; we accept plain packaging as undoubtedly an inevitability. However, we ask this committee to consider and address with us its implication for arts groups in Ontario.

Tobacco companies have achieved instant brand recognition through the use of corporate colours, logos and word marks in conjunction with the events they sponsor. In Toronto, for example, the well-known du Maurier Jazz Festival features the same brilliant red colour of the package on the billboards, on the banners which are around the city, on programs, on other kinds of promotion, as well as the words du Maurier, which as we know is not the name of the tobacco company; it's the name of the cigarette.

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All these elements carefully replicate the package for the product. This is advertising by another name, and that name is sponsorship. We believe that if plain packaging comes in, instant brand recognition will go; at that point, so will the sponsorship. For the arts that is the problem because a major source of private funding for arts groups

in Ontario will disappear. It is the view of the Arts and Health Alliance that replacement funds for tobacco sponsorship must be secured before this happens. Hence, we ask this committee to recommend to the government to work with us to examine particular models of replacement funds that advance the arts and the public health goals of this province.

One model for consideration comes from the state of Victoria, Australia, where a percentage of the tax on tobacco products is allocated to arts and sporting events that include a health promotion component. This model has gained international recognition and it's been strongly advocated by the World Health Organization.

At the same time, the alliance feels that a combination of public and private moneys could provide an even greater and more stable funding base for arts activity and health promotion and should be pursued.

In conclusion, in light of the implications of clause 5(a) of Bill 119, the Arts and Health Alliance requests that the standing committee on social development recommend to the government of Ontario that the Ministry of Health, together with the Ministry of Culture, Tourism and Recreation, begin to work immediately with the Arts and Health Alliance to:

(1) Investigate models of public funding to replace tobacco sponsorship, with part of these funds designated for appropriately targeted health promotion campaigns in conjunction with individual arts events.

(2) Research corporate sponsors for arts events that want to target the same market as the tobacco industry does currently.

(3) Establish an expanded funding base of public and private moneys for arts and health activities and promotion.

**The Chair:** Thank you very much. I think it's fair to say that this is probably the first time this specific issue has been addressed directly before the committee. Just at the outset, do you have any idea how much money goes into arts support from tobacco companies?

**Ms Bermonte:** If I may, I should also introduce myself as the associate director of the Toronto Arts Council. We don't have an exact amount because a lot of the funds from tobacco companies to arts groups are not done as grants. It's not an outright cheque for X amount of money. They're done through sponsorships either in kind or, for example, the du Maurier Theatre Centre at Harbourfront.

Even though an organization, an arts group, that is performing there is not receiving any kind of cash contribution from the company itself, they must have the logo on their brochure. The reason for that is that in a sense they're receiving an in-kind contribution, they're getting a subsidized grant, and that facility is available to the community. So it's very hard to say X amount of money goes directly to the arts from tobacco companies, because it takes many forms.

**The Chair:** I appreciate your difficulty in quantifying this, but you mentioned being in Toronto. In terms of arts sponsorship, is it possible to give us some sense—I'm talking here of all of the arts in terms of different produc-

tions and so on in Metro—of the percentage, roughly, that would be sponsored by the tobacco companies versus other businesses or corporations?

**Ms Bermonte:** At this time it's not. There hasn't been sufficient research done to determine that. In many ways, looking at it from an arts point of view, I just want to point out that the arts are operating and always have operated in many ways on the brink of survival. The highest subsidy, if you want to look at it in terms of subsidy, comes from artists themselves. It's not a matter of X million dollars will come out of funds to the arts community. Right now any money that is taken away from the community can send organizations that, as I mentioned, are on the brink of survival over the edge.

In response to your question, there really hasn't been a lot of research to say this amount of money is made available to arts groups in the form of sponsorship.

**Ms Hepburn:** As a matter of fact, that is one of the things the Arts and Health Alliance wants to do. We want to investigate that very item because that question is asked again and again and there is no satisfactory answer. In fact, the hidden moneys, the in-kind moneys are part of the problem. The other part of the problem is that tobacco companies do not want to say what they give because in some ways they're not direct funds. They're using them on promotion of themselves as promoters as well. It's hard to get a handle on what those funds are.

**The Chair:** Thank you both very much for coming before the committee and raising this issue and for your recommendation. We appreciate it.

ZELLERS INC

**The Chair:** I call on Mr Bob Seibel, the pharmacy general manager for Zellers Inc. Welcome.

**Mr Robert Seibel:** Good afternoon. Thank you for the opportunity to speak to you today. My name is Bob Seibel. I am the pharmacy general manager at Zellers. We are a large retailer that does just over \$3 billion in sales. We carry an extremely large variety of products in our stores. I would like to stress that we do not consider ourselves to be a drugstore, although 70 of our stores across Canada and 47 stores in Ontario do in fact have a pharmacy.

I would like to address the issue of Bill 119 and the impact it will have on our department store business if it is passed as currently written. There are three points I would like to highlight.

First, tobacco is a legal product available for sale in this province. Second, one possible result of this legislation would be to force the closure of 47 pharmacies in our department stores. Third, this legislation literally seeks to change the definition of the name "pharmacy" or what that means in a way which will be detrimental to the pharmacy sector and to retailing in general.

Tobacco is a legal product currently sold in a very large number of retail outlets. The size and type of these outlets vary widely and include everything from a small convenience store to a 70,000-foot Zellers department store and a 120,000-foot Woolco department store. We believe that any retailer should be allowed to sell any legal product and that no class of retailer should be



singled out for special treatment.

If today this government seeks to put limitations on the sale of tobacco in certain types of retail units, what are we to expect in the future? It has been said by some that it is inappropriate for a single retailer to sell both health products and tobacco because of the mixed messages that would be sent to the consumer. In a Zellers store, however, because of its massive size, pharmacies are located in an area away from where tobacco is probably merchandised. There is absolutely no relation whatsoever between the two areas, and in the intervening space a large number of products completely unrelated to either drugs or cigarettes are on display.

If today this arrangement is considered inappropriate and unprofessional, will it be inappropriate tomorrow to sell automotive products, to sell gardening supplies, to sell women's undergarments in a store that includes a pharmacy? The issue of what can be sold in a single store is particularly relevant to Zellers as a department store, since we sell such a variety of products while at the same time licensing pharmacists to operate in 47 of our stores in Ontario. I say licensing specifically, since Zellers does not own the pharmacies that operate in our stores. They are owned and operated by the individual pharmacists in place.

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The pharmacists in our stores are health care practitioners with authority over the space taken up by the pharmacy itself, and with no involvement at all, financial or otherwise, with the rest of the store. I cannot stress enough the fact that pharmacists in our stores have no control over any space other than the few hundred square feet taken up by their pharmacy.

Some presenters have argued before this committee that pharmacists cannot be both health care professionals and retailers. In our stores, pharmacists are not retailers, they are just health care professionals. Zellers is the retailer. However, we should not be forced to make a choice between selling tobacco in one part of our store and allowing a licensed pharmacist to operate a relevant service to our customer in another part of that same store.

If Bill 119 does force Zellers and other similar retailers to make a choice between selling tobacco and licensing pharmacies, then decisions will be made according to the profitability of each of these lines of product. I stress again that we believe we should not be forced to make this choice. If we must however, then the jobs of over 90 licensed pharmacists and 100 dispensary assistants working for them will be put at risk.

In the situation of a department store, it is simply not a case of, "Will we make money and continue to sell tobacco or pharmacy?" We will make a business decision based on your objective that we have to carry one or another, and one part of that industry will immediately shut down in our store.

The loss of these jobs and the inappropriate intrusion into the freedom of retailers to sell legal products is made worse because it will not further the objectives of this bill. Forcing Zellers to close pharmacies and put pharmacy licensees out of work and out of their own busi-

nesses will not lead to a reduction in smoking, nor will it prevent young people from obtaining cigarettes. You have heard from a number of presenters who have admitted that there will be no demonstrable benefit from a ban on tobacco sales in pharmacies.

Finally, I would like to focus mainly on the issue of the definition of "pharmacy." According to the Health Disciplines Act, a pharmacy is defined as follows: "'pharmacy' means a premises in or part of which prescriptions are compounded and dispensed for the public, or drugs are sold by retail."

One of the functions of the Ontario College of Pharmacists is to accredit pharmacies, which as I have stated is the area where prescriptions are compounded and dispensed. However, what your legislation is in effect proposing is that the entire 70,000 square feet of a Zellers department store will now be defined as the pharmacy. The college of pharmacy today defines our pharmacy as 400 square feet, the actual dispensary and the over-the-counter medication restricted to sale in a pharmacy. You are literally looking at changing that definition from 400 feet to 70,000 feet, and I believe you are unaware of the implications.

We believe this is a ridiculous proposition because the College of Pharmacists will now have jurisdiction over 70,000 square feet of space, including lingerie, sporting goods and everything else you could think of which it has no interest in controlling or in fact no right to control.

As you may be aware, we are owned by the Hudson's Bay Co, which owns the Bay. I've given you the example of a Zellers store and I would like to give you a further example. If the Bay contained a pharmacy—for example, in BC there are several Bay stores with pharmacies—on the fifth floor of one of its locations, and it sold tobacco on the first floor, the proposed legislation in Bill 119 will effectively make the entire Bay store into a pharmacy. So now you will include in this "pharmacy" definition furniture, linens, restaurants, electronics, appliances, kitchenware and so on, all part of the pharmacy. I'm sure this was not the intent of your legislation.

When the government considered an Act to Amend the Regulated Health Professions Act, representation was made to the government by the Ontario College of Pharmacists to ensure that pharmacists would only be responsible for sexual abuse misdemeanours that occurred in the dispensary. The Ontario College of Pharmacists fully appreciated why it requested this special amendment. It knew that pharmacists could only be responsible for sexual abuse that took place in the pharmacy lockup or cage and that they could never be responsible for an offence if it occurred in their entire normal store, or in this case, a 70,000-foot department store, or in the case of the Bay, four floors away. The Ontario College of Pharmacists is aware of the definition of a pharmacy, and the front shop of a Zellers store or the other four floors of a Bay store are not within its definition.

As a point of reference, please note that the word "premises" used in the definition of a pharmacy is not defined in any legislation or regulation under the Health Disciplines Act. Your legislation is flawed in our opinion because you are trying to define a pharmacy beyond the

scope of the Health Disciplines Act and beyond the jurisdiction of a pharmacist as contained in the Regulated Health Professions Act.

There is another important flaw in your definition. Under the Retail Business Holidays Act, there is a provision on Sunday opening that states that no retailer can force an employee to work, no landlord can force a tenant to open and no licensor can force a licensee to open. So by legislative power in this province, I cannot force one of my pharmacists to open Sunday. If your legislation goes through the way it's written, you have just closed the total department store of Zellers, because you have made the definition of the pharmacy the entire 70,000-square-foot store. If that pharmacy from BC was located at the Bay in downtown Toronto, you have closed the entire Bay department store due to this definition.

In some of our Zellers stores, our pharmacies are not open Sundays. Under the lock-and-leave provision of the Ontario Legislature, we close the pharmacy with a six-foot movable gate. Under Bill 119 however, the pharmacy will be defined, as we stated, as the entire 70,000-square-foot store, and if the pharmacist elects not to work or operate, we would be forced to close the entire store.

We think the standing committee is having difficulty distinguishing between a pharmacy and a retail drugstore. They are two distinctly different entities, as evidenced by a Zellers store. We have a 200-square-foot pharmacy in the back and the other 69,000 square feet is truly a department store made up of various departments. If you can appreciate and understand that there is a difference between a pharmacy and a drugstore, then you must similarly appreciate that there is a difference between a health care professional and a retailer. The licensed Zellers pharmacist is the health care professional; Zellers Inc is the retailer. That is why we should be free to sell at Zellers any legal product and we should also be free to provide an important and valuable service to our customers by licensing space to pharmacists.

This bill, if passed in its current form, will not lead to any public health benefits. It will not stop people from purchasing cigarettes. It will not lead to changes in what people think when they shop in a Zellers store. What it will do is threaten the livelihood of over 190 people who are currently providing front-line health care. At least 190 jobs and several small businesses represented by my licensees will be placed in jeopardy.

This legislation will give the Ontario College of Pharmacists and the government a new and untenable definition of what constitutes a pharmacy. Such a flawed definition would leave itself open to constitutional challenge. My main purpose for being here is to ask you to consider the definition, because if push comes to shove, if you cause me to close my whole store over this bill, we will fight.

Thank you for the opportunity to make this presentation and I'd be happy to answer any questions you have.

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**The Chair:** Thank you for setting out a particular element of the bill. I think one can see the issue there. We have questions on it, beginning with Ms Haslam.

**Mrs Haslam:** A couple of comments first. On page 2 when you talk about "inappropriate and unprofessional," will it be inappropriate tomorrow to sell automotive products which are not addictive, gardening supplies which are not addictive? Undergarments, whether they are worn by everyone or not, are not addictive.

**Mr Seibel:** In the province I live in, pesticides are now being brought before legislative committees because they're trying to ban them. I as a consumer want to use them. A government committee such as this is now deciding if a store like ours should carry them.

**Mrs Haslam:** With the proper qualification, certification to carry dangerous products under—

**Mr Seibel:** No. They're just saying we cannot use them on our lawns. I take exception to that, but I bow to the stature of this committee.

**Mrs Haslam:** What I'm talking about, though, are addictive cigarettes. When you compare them to other products in your store, we have to look at another type of thing and that is addictive cigarettes.

Could you explain a couple of things to me? You say you license pharmacists; you don't hire them. How is that licensing done?

**Mr Seibel:** It's a sublease, in effect. A pharmacist comes into our organization. He owns the pharmacy cage, the fixtures, the inventory in the dispensary. He hires the technician and the other pharmacist, and he operates it as a small business. He carries a bank loan through a recognized bank. He files income tax as a sole proprietor or a small company.

**Mrs Haslam:** That's what I wanted to know.

On page 3 you talk about the lines of products and the choice that you have to make in a business decision. We've been informed by many sources that the profitability and the markup on tobacco—that it's not a good profitability product, that what it does help is with the cash flow because you end up having the product come in and not paying for it, and then you sell it and it increases your cash flow, that when you take a look at the profitability and the markup on your tobacco, especially when you use it as a loss leader, it is not a profitable product compared to some you sell.

**Mr Seibel:** Because you're not allowed to advertise tobacco, we do not use it as a loss leader. It is a profitable product. You can order cigarettes three to five times a week. You can literally turn cigarettes 40 to 45 times a year.

**Mrs Haslam:** Which helps your cash flow.

**Mr Seibel:** Which will be very profitable.

**Mrs Haslam:** So tobacco, adverse to what other people tell us, is a profitable problem.

**Mr Seibel:** Absolutely.

**Mrs Haslam:** That's not what we're hearing from other stores.

**Mr Seibel:** With respect, in our company it is a profit setter.

**Mrs Haslam:** Is it the volume?

**Mr Seibel:** It's not the volume as such, it's a combi-



nation of volume and other traffic. If you cause a customer to go someplace else to buy cigarettes, they will buy shampoo, they will buy a rake, they will buy an undergarment.

Our problem as a department store is that there are three major competitors in this country: There is Woolco, K mart, ourselves, and unfortunately Wal-Mart is coming. We are the biggest operator of pharmacies in the department store area. K mart, for example, has under 20 pharmacies. They could make the decision to go out of pharmacy and use tobacco in massive displays. We are now at a competitive disadvantage in our own business.

We have never tried to put one thing in our store that would cause us to not be competitive with one of our other target groups. We do not consider, for example, pharmacy as a competitor. Our competitors are major department stores. If we had a level playing field that all department stores carried or didn't carry, that is not my problem. My problem is, the way the legislation is set up and the way history has driven it, K mart, which is a major retailer, does not have pharmacies.

**Ms Carter:** They do in my city.

**Mr Seibel:** I understand. As I stated, they have under 20 in 122 stores.

**Mrs Haslam:** Would you be recommending taking a look at a square footage idea around the sale of tobacco?

**Mr Seibel:** I believe the health professional is a small area in the store, and I think this body has every right to govern that part. For example, I would never let my pharmacist sell tobacco. Okay?

**Mrs Haslam:** That's not the problem. We're dealing with a perception and young people and mixed messages, and that's a concern. However, I see your concern when you talk about 70,000 square feet. It is a conundrum, I think, that the committee will have to look at, so I'm asking you, would you recommend we look at it as a square-foot problem?

**Mr Seibel:** You also have to be careful then of the size you look at. For example, depending on the definition, Bi-Way is a department store. Bi-Way is in some cases 12,000 to 15,000 feet. There are some drugstore formats, such as Herbie's if they're still around, that are over 20,000. So by using square footage—

**Mrs Haslam:** You miss a few and catch a few?

**Mr Seibel:** Exactly.

*Interjection.*

**Mrs Haslam:** No, I know, it didn't work with Sunday shopping. I don't think it's going to work in this area.

**Mr Seibel:** But you've found a way to close us.

**Mrs Haslam:** No, I think we've found a way to address it as a health issue, and that is really what this committee has to deal with. I've been told that stores will probably get around this by moving cigarettes right to the front wall, walling them off and having a separate entrance, which is one way that a store could deal with the problem of what a pharmacy is and what a pharmacy isn't. Would that be something Zellers would consider?

**Mr Seibel:** I think what Zellers is doing is what Zellers is doing right now. We're saying to you that we

think it's an unfair level playing field and we're asking you to adjust it.

**Mrs Haslam:** Would a level playing field be a tobacco control board?

**Mr Seibel:** I don't know. That's your decision; it's not mine. All I want is, when I'm competing with K mart and Woolco and Wal-Mart—

**Mrs Haslam:** If a tobacco control board had cigarettes and none of you did, is that a level playing field?

**Mr Seibel:** Yes.

**Mrs Haslam:** Okay. Thanks.

**Mr McGuinty:** Mr Seibel, thank you very much for a very informative presentation. I think you've explored more fully than any other presenter the implications of the definition and the contradictions that raises.

What we're talking about here at the end of the day, and you must have heard this before, is the symbolic value of associating a pharmacist, a practitioner in health care, with the sale of a tobacco product, which we know causes health problems.

I personally have difficulty seeing that symbolism. I think it's overshadowed dramatically by the much more dramatic contradiction between our telling our children they can't smoke, and yet when they turn 19 they can smoke; our telling our kids that they can't smoke, but yet it's a legal product. I see that as the contradiction. I see that as symbolism that's going to overshadow dramatically the kind of symbolism that the government's trying to get at through this particular bill.

Whereas you might be able to make the argument—I don't believe it, though—for smaller operations, smaller drugstores or pharmacies, you sure as heck can't make it for a big operation like yours. If I was to stand in front of a Zellers store somewhere in this province and simply ask people whether they thought Zellers was primarily a health care operation, I don't think many of your customers are going to give me the answer "yes." I think by and large they'll see it as providing a variety of services and goods.

**Mr Seibel:** I respect your opinion, but with respect what you're going to do is make that customer find out, because when you stand there and ask him if we're a health care professional, you may have made me not one. If this legislation goes through as such, we will have to decide between tobacco and pharmacy, and quite frankly, pharmacy is a very small cog when we are fighting other department stores. Make no mistake, our fight is with department stores, and if in our opinion to fight a Wal-Mart, to fight a Woolco, we have to keep tobacco in the back pocket, we will keep it.

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I have pharmacies that have been in this province for 25 years. I have pharmacists who have worked for me as corporate pharmacists and have gone on to open their own stores. We're going to have to explain to these people why they can no longer function in our store.

I understand your idea on the contradiction, and if I could, I'd like to give you a small example from my personal life. I'm Catholic and I'm a pharmacist and all

my life I dispensed birth control pills and I sold condoms. Honest to God, I can't figure out why. But I know that the person out there who doesn't believe as I do has that choice. I don't want them to buy condoms in backyards, on the school ground, wherever. It's a legal product, and if this committee were to say, "It is no longer a legal product; we're going to take it off the shelves," I'll get up and walk out of here, but if you're going to tell me, "You as a department store can't sell it, but K mart can," I have a problem.

**Mr Jim Wilson:** Thank you, sir. I had to watch your presentation via the television in my office because I was actually doing an interview at the same time with a radio station on the telephone. I found your comments to be most persuasive.

It's been a confusing day for us, I have to tell you, because we're told a lot about perception and the fact that the government has said many times, as you've heard, that pharmacists have to make up their minds whether they're retailers or health care professionals. Yet when I read the Environics survey that was done for the Ontario Campaign for Action on Tobacco, I note in their results summary that it says a majority of 67% consider pharmacies and drugstores in Ontario to be retail stores that sell a variety of products. Just 24% see them primarily as health care retailers.

I have argued that all the way along and I thank the Ontario Campaign for Action on Tobacco for actually doing an Environics survey on it, because my perception of not only what we call the non-traditional drugstores such as yourselves, but other drugstores, is that people increasingly see them as large retailers, which I'd like you to comment on.

**Mr Seibel:** I think that if you, as a committee, were to research simply Metro Toronto, you will find in medical clinics a pharmacy half the size of this room that dispenses only, has some OTC product. You would not find Pampers in there, you would not find bubble gum in there, you would obviously not find cigarettes. That is a true definition of a health professional area.

If you move out to a Shoppers Drug Mart, a larger format, if you move to a department store such as ourselves, if you move to a grocery store, we dispense the same product, we give the same patient counselling, we give the exact same service, but your perception is that we're retailers. The truth is that we're health care givers.

I have worked in this industry long enough to work with a discount drug chain and with a full-price drug chain, and I'm usually in front of a committee like this explaining why one guy has a dispensing fee of two bucks and another guy has a dispensing fee of 12 bucks. The answer quite simply is that we are health care professionals; we choose to discount our fee.

What I'm saying to you, in your perception, is that the guy in the medical clinic, the guy in the food store, the guy in Shoppers Drug Mart, the guy at Zellers, we are all giving the same professional care.

I do not doubt for one minute that if you allow me to sell cigarettes, I'm going to have trouble with my own

licensees. They will probably be telling my customers, "Well, I don't think we should be selling it." But I need a level playing field; you are quite right.

The other thing you have to look at is the economics of pharmacy. It's fine to say I want to keep it on a professional services and health standards basis, but we also have to look at the reality. If you go into a shopping centre today that's a regional mall, you will either rent an 8,000-foot drugstore or you will go into my store and take 200 feet as a licensee. If you have an 8,000-foot store, that's one heck of a large pharmacy, or you'd better find a hell of lot of other products to put into it.

Every little bit of profit you can make to drive traffic and to make profit pays your bottom line so you can give the professional services to those customers who need them. Otherwise, you're going to end up in a situation down the road where big regional shopping centres don't have pharmacies. You will go to secondary strip malls where they can afford the rents.

**The Chair:** Thank you very much for coming before the committee this afternoon and for your presentation.

CANADIAN SOCIETY OF HOSPITAL PHARMACISTS,  
ONTARIO BRANCH

**The Chair:** I call Mr Gordon Murray, the president of the Canadian Society of Hospital Pharmacists, Ontario branch, and someone else who will identify herself momentarily. Welcome, both, to the committee.

**Mr Gordon Murray:** Andrea Cameron, our senior delegate to our national organization, is here with me today.

I'd like to thank the committee for this opportunity to present our views on the bill that's currently before you. I'd like to start off by just characterizing our organization so you have some understanding of who we are and who we represent.

The Canadian Society of Hospital Pharmacists is Canada's national voluntary association of pharmacists who share an interest in pharmacy practice in hospitals and related health care settings. The Ontario branch is one of eight branches and currently represents approximately 900 pharmacists practising in Ontario's health care institutions today.

The mission of our national association is to provide leadership in all aspects of pharmacy practice in hospitals and related health care settings, to promote the provision of patient-focused pharmacy services, and to represent and provide services to the membership.

In terms of Bill 119, the Tobacco Control Act, we do not presume, in a sense, to review the information about the negative effects of tobacco in our society. I think that's been well established. The Ontario branch, at its 1990 annual general meeting, presented a resolution to membership supporting the ban on tobacco sales in pharmacies as proposed by the Ontario College of Pharmacists, and it was accepted. Therefore, our position is to recommend the banning of tobacco products from health care facilities and pharmacies as specified in the proposed legislation.

We believe that pharmacists, in practising pharmaceutical care, have the opportunity to provide positive impacts



on patients' health care, and in such regard, pharmacists can provide this even in the area of smoking in that the Canadian Pharmaceutical Association has already prepared a smoking cessation counselling program for pharmacists entitled "Butting Out For Life." Pharmacists would be more appropriate in providing their skills in that area than providing tobacco to the marketplace.

Our second recommendation in a sense speaks to that in that we recommend the adoption of one of the recommendations from the Lowy inquiry, which speaks to looking at establishing "pilot projects to examine and assess alternative reimbursement and payment mechanisms which would reward the provider of professional pharmaceutical services and be independent of the sale or dispensing of a drug." We think there is a role for pharmacists in terms of trying to end the problems of tobacco in society.

We also believe that the legislation, I think as others have spoken to, should go further than simply prohibiting sales but also look at the issue of licensing sales. Therefore, our third recommendation is that we do recommend the licensing of the sale of tobacco products.

**The Chair:** I note for the record that in your written submission you set those out in some detail, and we appreciate that. We'll begin questions with Ms O'Neill.

**Ms O'Neill:** You have a different slant and emphasis than many of the other presenters. I wonder, for the record particularly and for those watching, if you'd say a little bit more about the Lowy recommendation that you feel fits into the backdrop of this piece of legislation.

**Mr Murray:** Certainly. I guess we have the good fortune that we are not paid for the dispensing of a product; our responsibilities in hospital pharmacy are provision of services to patients, as well as the physical handling of the product. Therefore, we have focused on those recommendations in Lowy that spoke to that role of pharmacists, because we feel it's an undeveloped role in society, as Professor Lowy pointed out in his own report.

I believe that in the report he estimated that if pharmacists were providing that kind of service to the public here in Ontario, there was an estimated, at the time of the report being issued, \$350 million worth of recoverable moneys to be saved through the drug benefit system for an investment of approximately \$50 million in improving pharmacists' education and reimbursement in the area providing cognitive kinds of service.

He spoke to a number of different examples. I don't believe there is a current model that any of us could point to and say explicitly that this is the way to go, but I think there are a number of alternatives to be explored. The one that I'm most familiar with at the moment is the initiative in Quebec for the Opinion pharmaceutical where they're reimbursing pharmacists there for intervening to do things like set up withdrawal schedules for benzodiazepines, and to counsel physicians about problem drug therapy to eliminate or reduce drug therapy in patients etc, and therefore the pharmacist is exercising his judgement in the best interests of the patients and positive outcomes.

1630

**Ms O'Neill:** How would that be billed? Would that be billed by the hour? Do you know how they're doing it in Quebec?

**Mr Murray:** Currently in Quebec it's done on fees based on a schedule of reimbursable interventions. For example, if a pharmacist in Quebec in his opinion feels that a prescription is inappropriate for a patient and refuses to fill it on those grounds, he will fill out the appropriate intervention and be paid the same fee as if he'd provided the drug, and that he document it.

They'll admit a weakness at the moment in their system with that right now about notification to the physician, whereas Lowy, in terms of his talking about this kind of model, did speak to the idea that there should be appropriate communication of decisions like that.

**Ms O'Neill:** And you would agree with that?

**Mr Murray:** Exactly. We're not doing anything for a patient's health care if the pharmacist is saying one thing, the physician is saying another and the poor patient is trapped in between. In terms of their reimbursement for some other acts, it is greater than their dispensing fee, depending on exactly the act. For example, developing a benzodiazepine withdrawal calendar and working a patient through it I believe ends up being reimbursed at approximately double the dispensing fee.

The way they've set this up in Quebec as a model to test and prove out is that the pharmacy owners in Quebec have set up a fund using 1% of what would be considered the likely income to be received from their dispensing for the comparable thing to the drug benefit program here in Ontario, and then the pharmacists apply to that fund for reimbursement for the acts that are on the schedules.

**The Chair:** I'm sure somebody told us this at some point in our hearings, but after a while it all begins to mesh, but in terms of hospital pharmacies in Ontario, how many are there and how many members do you have as hospital pharmacists in Ontario, roughly?

**Mr Murray:** At this particular point in time, it's hard for me to give you a precise number in that for years we had the good fortune of the Ontario Hospital Association supporting a couple of pharmacists being on staff. One of the things they did was regularly survey to see what was going on in terms of positions in hospitals etc, but that service was discontinued a couple of years ago. The last numbers I'm aware of would say that the current situation would be approximately 1,200 to 1,300 pharmacists practising in hospitals. Our membership is somewhere in the neighbourhood of two thirds to 75% of that.

**The Chair:** In how many hospital pharmacies? Would you have any sense of that?

**Mr Murray:** In terms of hospitals in Ontario, I think virtually all have either a pharmacist on staff or on staff in some sort of retained way. They may actually use nurses or in some cases pharmacy technicians to do physical distribution in the hospital, but they will retain a pharmacist as you set up appropriate procedures etc.

**Ms Carter:** I was just wondering, in view of our last presentation, what your definition of a pharmacy would be.

**Mr Murray:** In terms of provision of tobacco products, I would agree with the definition in the act in that I do see a problem of associating the sale of this product with health care provision, and whether you have a 70,000-square-foot or a 700-square-foot location, the mixed message does occur when in a sense you can pick up your tobacco at one end of a store and you can pick up your prescription, if you like, for your morphine for your lung cancer at the other end.

It's a dilemma. I understand where he's coming from as a retailer. I think that's why he would appreciate the idea of a licensing system that took it and made a completely level playing field for him. Nobody wants to, I think, in this legislation give anybody an unfair advantage in terms of marketing tobacco products, and I guess that's the tough job you've got of trying to make sure you don't do that inadvertently.

**The Chair:** Thank you both very much for coming before the committee this afternoon.

LUNG ASSOCIATION,  
METROPOLITAN TORONTO AND YORK REGION

**The Chair:** I call our last witness for today, Mr Ian Morton, the environment coordinator for the Lung Association, Metropolitan Toronto and York region. Welcome to the committee, Mr Morton.

**Mr Ian Morton:** It's been a long day, it sounds like.

**The Chair:** But our days are always interesting.

**Mr Morton:** That's fun; that's good.

**The Chair:** We've learned a lot.

**Mr Morton:** My name is Ian Morton. I'm the environment coordinator for the Lung Association, Metro Toronto and York region. On behalf of my organization I want to congratulate the government and the opposition parties for introducing Bill 119 and ensuring its second reading and really taking the time to hear from all the different groups and their comments. I know you've been all around the province and you've heard from a number of colleagues of mine from the Lung Association and we do appreciate the amount of time and interest you've taken in this issue.

I'm going to be speaking to a very specific issue related to the bill. That's section 9, dealing with environmental tobacco smoke in public indoor settings. I will be referring to environmental tobacco smoke as ETS, so please stop me if there's any unclarity as far as my acronyms are concerned and I can clarify any of the terms I'll be using.

The Lung Association's concern about this section is based on the following. In 1986 the United States government estimated that approximately 86% of American non-smokers were routinely exposed involuntarily to ETS at home, at work or in other public indoor air settings. I suspect these figures would probably accurately reflect exposures that are happening here in Ontario. Why that would be a concern to our organization or why it is a concern in our organization is that we spend approximately 90% at least, minimum, of the time within the indoor environment.

As many of you have heard throughout these hearings, there are many documented health or associated health

effects due to exposure to secondhand smoke. I would refer to the OCAT document which has been submitted to you. They've gone extensively through some of the health effects, so I'm not going to spend much time on it. But none the less I would like to point out that ETS puts far more hazardous substances into the air than exhaled smoke does, and contains twice as much nicotine, three times as much tar and 50 times as much carbon monoxide.

Especially dangerous, in my opinion, are some of the toxic, some of the carcinogenic compounds which are released, specifically 2-naphthylamine and 4-aminobiphenyl. These are just two of the more powerful carcinogens which have been identified with ETS and have been released with the Environmental Protection Agency's recent report on secondhand smoke. The EPA has gone so far as to suggest that the impact of these exposures may be so great that there should be no exposure at all, that the exposure limit should be as low as possible. In other words, I guess my point would be that there should be no tolerance for smoking at all in any public indoor air setting, that it should be banned altogether.

Many of the chemicals which have been described through the OCAT submission are produced through the elements which are added during the manufacture of tobacco. I'm not sure many of you have seen this and I would be happy, Mr Chair, to submit this if this would be useful for your committee. We received this through the freedom of information act from Health and Welfare.

As I'm sure some of you are aware, the tobacco manufacturers had to submit this back in 1989, which listed all the ingredients that went into a cigarette. I don't have time to summarize 11 pages, but I will point out some interesting goodies in here. Specifically, some of the ingredients include shellac, acetone, turpentine and many other lovely little ingredients which, during combustion, will produce other nasty chemicals which I've referred to earlier. This is a public document.

1640

**The Chair:** Sorry to interrupt; if the clerk could get that copy we'll make one and give that back to you.

**Mr Morton:** In addition to the side-stream smoke being released through ETS, I would add that ETS can act synergistically with an indoor environment to increase the severity of adverse health effects. The magnitude of the synergistic effect is always greater than the sum of the individual effects.

Asbestos and smoking are the most dramatic example of the greater health damage resulting from these combined exposures, but other substances appear to act synergistically with tobacco smoke, which would include chloromethyl ethers, silicon dioxide and radon. This has led some researchers in the United States, specifically with the EPA, to suggest that ETS poses a greater health risk than all the hazardous pollutants combined.

When you think that, at minimum, there are about 4,000 identified contaminants in secondhand smoke, and that for some of them, for example, arsenic, when we're dealing with this in the ambient environment, we have



very strict laws and regulations regarding their use and disposal in Ontario right now—in many public indoor air settings, people can be routinely exposed to quite high levels of these toxic elements.

Not only does ETS substantially increase the level of toxic gases to indoor air; it rapidly disperses throughout indoor environments and persists long after smoking ends. Moreover, most of the ventilation systems which exist in many indoor environments are not designed to handle the specific demands associated with removing many of the toxic elements which are contained within tobacco smoke.

As well, research conducted by the Lung Association this past year has shown that even if you have ventilation systems which are equipped with high-flow filtration systems, the removal rates are limited. In other words, even if we have some of the best equipment to remove some of these toxic elements, there's little that, in many cases, filtration can do.

Clearly, source removal and prudent avoidance are the best two strategies to mitigate exposure to ETS. However, I would suggest that Bill 119, specifically section 9, provides us with a tremendous opportunity to have some regulatory emphasis to restrict exposure in public indoor settings to this hazardous substance.

Given the overwhelming evidence documenting the deadly properties of ETS, the Lung Association, Metro and York region, is asking for a comprehensive ban on smoking in all public places. These indoor settings would include recreation centres, shopping malls, fast-food outlets, hockey arenas; the list is essentially endless. These public places often employ young people who could be subjected to the dangers of ETS. As well as the young people who are often exposed, I also point out that there are many adults who are working in these types of centres who are going to be exposed to ETS as well.

Currently in Ontario there is no legislation which protects those types of workers who would be exposed to ETS; for example, if they were working in the Eaton Centre and in the long term developed a lung ailment or something else and had to give up their work. The Occupational Health and Safety Act does not cover that type of exposure. In summary, it's reasonable to assume that a large proportion of the labour force could be left unprotected and exposed to a serious pollutant under the proposed legislation.

Equally, the Ontario Smoking in the Workplace Act has not protected workers exposed to ETS in many workplace settings. There's no definition of what a designated smoking section is, which essentially allows for smokers and non-smokers to be on separate sides of the room with an imaginary line drawn in the middle. It's anybody's guess, in many situations. Moreover, the Ontario law does not require smoking and non-smoking areas to be independently ventilated. If the smoke-polluted air is simply recirculated, even in large, ventilated, modern buildings, the carcinogenic risk to which many non-smokers may be exposed is still unacceptable. The legislation in effect currently gives virtually no protection to an employee working for an employer who wishes to allow smoking in the workplaces.

Since many of the hazardous materials contained in environmental tobacco smoke have no safe level, the Lung Association is encouraging the province of Ontario to strengthen section 9 of Bill 119 and ban smoking from all public indoor and workplace settings.

**Ms Carter:** You mentioned the synergistic effect of smoking in workplaces. Of course, some workplaces do have their own chemical hazards. You mentioned radon, which I take it could be uranium mines. Then there are factories that have problems—

**Mr Morton:** Or your residence too, your home. I'm speaking to associations here. There's a strong association between the two working together to produce an effect.

**Ms Carter:** Sometimes I think smoking has been used as an excuse in the sense that if somebody was trying to prove that their workplace had caused health problems and they were also a smoker, they would be told, "It's because you are a smoker," but it's probably two things or more coming together and increasing the effect.

**Mr Morton:** If we can measure it; sometimes that's very hard to do. Most notably with asbestos, we know there is a very strong relationship between asbestos exposure and tobacco exposure leading to the development of mesothelioma, which is a very specific lung cancer. In some cases, yes, we are concerned that the two combined could have a greater health impact.

**Ms Carter:** There would be the added benefit that if smoking were prohibited in such workplaces, then any illnesses that did occur would be directly traceable to what was there. There wouldn't be that same dilemma.

**Mr Morton:** It would reduce it, yes, possibly. There are many factors when we're talking about indoor air quality and sick building syndrome which have to be taken into account. But reducing the loading to the air would hopefully lead to improved health of your workforce and reduce long-term health care costs as well.

**Ms Carter:** So you are advocating no smoking in workplaces?

**Mr Morton:** Correct.

**The Chair:** Thank you very much for coming before the committee this afternoon for your presentation.

Before we break, just a reminder that we're back here tomorrow morning from 9:30 until 10:30, roughly. You should all have your flight information and airline tickets for tomorrow afternoon. We begin at the Westin Hotel in Ottawa at 3 o'clock tomorrow afternoon.

**Mr Tony Martin (Sault Ste Marie):** Is the clerk providing transportation from here to the airport?

**The Chair:** You're on your own. You should have been given all the information.

**Mr Martin:** I arranged my own fare, so I didn't get any of that. That's okay. From time to time, I've been on committee where there have been cars out there and we all took off to the airport, but I guess not this time.

**The Chair:** Wednesday afternoon and evening and Thursday morning and afternoon we're in Ottawa. That brings great joy to the hearts of Ms O'Neill and Mr McQuinty. We're all looking forward to that.

The committee adjourned at 1647.

## STANDING COMMITTEE ON SOCIAL DEVELOPMENT

**\*Chair / Président:** Beer, Charles (York-Mackenzie L)

**\*Vice-Chair / Vice-Président:** Eddy, Ron (Brant-Haldimand L)

**\*Carter, Jenny** (Peterborough ND)

**\*Cunningham, Dianne** (London North/-Nord PC)

Hope, Randy R. (Chatham-Kent ND)

**\*Martin, Tony** (Sault Ste Marie ND)

**\*McGuinty, Dalton** (Ottawa South/-Sud L)

**\*O'Connor, Larry** (Durham-York ND)

**\*O'Neill, Yvonne** (Ottawa-Rideau L)

Owens, Stephen (Scarborough Centre ND)

**\*Rizzo, Tony** (Oakwood ND)

**\*Wilson, Jim** (Simcoe West/-Ouest PC)

*\*In attendance / présents*

### **Substitutions present / Membres remplaçants présents:**

Haslam, Karen (Perth ND) for Mr Hope

Villeneuve, Noble (S-D-G & East Grenville/S-D-G & Grenville-Est PC) for Mr Jim Wilson

Wiseman, Jim (Durham West/-Ouest ND) for Mr Owens

### **Also taking part / Autres participants et participantes:**

O'Connor, Larry, parliamentary assistant to Minister of Health

**Clerk pro tem / Greffière par intérim:** Grannum, Tonia

### **Staff / Personnel:**

Boucher, Joanne, research officer, Legislative Research Service

Gardner, Dr Bob, assistant director, Legislative Research Service



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## Legislative Assembly of Ontario

Third Session, 35th Parliament

## Assemblée législative de l'Ontario

Troisième session, 35<sup>e</sup> législature

# Official Report of Debates (Hansard)

Wednesday 16 February 1994

# Journal des débats (Hansard)

Mercredi 16 février 1994

## Standing committee on social development

## Comité permanent des affaires sociales

Tobacco Control Act, 1993

Loi de 1993 sur la réglementation  
de l'usage du tabac



Chair: Charles Beer  
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## STANDING COMMITTEE ON SOCIAL DEVELOPMENT

Wednesday 16 February 1994

The committee met at 0934 in room 151.

## TOBACCO CONTROL ACT, 1993

LOI DE 1993 SUR LA RÉGLEMENTATION  
DE L'USAGE DU TABAC

Consideration of Bill 119, An Act to prevent the Provision of Tobacco to Young Persons and to Regulate its Sale and Use by Others / Projet de loi 119, Loi visant à empêcher la fourniture de tabac aux jeunes et à en réglementer la vente et l'usage par les autres.

ONTARIO FLUE-CURED TOBACCO  
GROWERS' MARKETING BOARD

**The Vice-Chair (Mr Ron Eddy):** Good morning, ladies and gentlemen. The first presentation will be made by representatives of the Ontario Flue-Cured Tobacco Growers' Marketing Board. Welcome to the committee.

**Mr Albert Bouw:** My name is Albert Bouw, chairman of the Ontario Flue-Cured Tobacco Growers' Marketing Board.

**Mr George Gilvesy:** I am George Gilvesy, vice-chair of the Ontario Flue-Cured Tobacco Growers' Marketing Board.

**Mr Bouw:** I believe we've distributed a copy of our little document. There is a little further information in the back of it that you probably will be able to look at at your leisure at some other point: the Mackenzie Institute report. If I may, I'll proceed with our short presentation.

In general terms, we, as producers of the primary product, have concerns that future regulations will jeopardize the viability of our industry and contribute to a growing social problem.

It has been recently recognized by the federal government we have a serious contraband problem. Years of excessive taxation and anti-smoking regulations have resulted in a huge market for underground tobacco and the criminal distribution networks to supply it.

Last March, when we made a submission to the Ontario Ministry of Health committee responding to the discussion paper on this proposed bill, we told the committee members an estimated 20% of the tobacco products in Ontario were contraband. Today, this market share has increased to 40%.

It is unlikely that the limited action taken by the federal government to reduce tobacco taxes will break up the firmly established black market distribution, the networks that exist in Ontario. Further legislative restrictions on the sale and use of tobacco will serve only to increase black market demand.

The primary goal of the proposed control act, as we understand it, is to attempt to curtail tobacco use by minors. We wholeheartedly agree with this goal, but believe the method is flawed.

This proposed legislation would restrict sale of tobacco products to minors but does nothing to ensure that legal outlets are the only source of tobacco. In a column in the Toronto Star recently, a grade 13 student, Elliot Johnson, pointed out the hollowness of age restrictions in a market

with a growing black market problem. He writes:

"One easy way around this problem for many teenage smokers has been to buy the cigarettes illegally where the vendors are unlikely to ask for proof of age since they are already breaking the law." I think that's a very critical point.

We also quote an independent report written by the Mackenzie Institute. The report states:

"Whatever the importance of discouraging smoking on the one hand and gathering taxes and duties on cigarettes on the other, the facts revealed in this report point to less obvious but potentially graver dangers to our nation's health. Through a combination of factors relating to cigarettes, a section of the traditionally law-abiding population is being conditioned to break the law on a daily basis"—I think that's very, very serious—"a new criminal class is being mobilized on the reserves, and the old criminal class across the country is arming itself as though for guerrilla warfare."

I think we're seeing more and more and hearing more about that every day in newspapers and on radio, and so on. I think we all have to be very, very conscious of that fact. I think what these two things are pointing out is that the accessibility of cigarettes to minors is very readily available today through the non-legal channels and that's what has to be stopped.

The proposed restrictions on who could legally sell tobacco products will end up playing into the hands of those involved in the illegal trade. Pharmacies are legitimate retailers who are likely to carefully abide by the regulations concerning the sale of tobacco products to minors. What better place than a drugstore to monitor who they're selling cigarettes to? There's probably no other place that would scrutinize it any closer than a drugstore.

Fewer legal outlets means more people will turn to illegal outlets. Further requirements on other merchants who wish to sell tobacco, such as specific retail licensing, will put yet another burden on small retailers struggling to compete with a black market already holding all the competitive cards. Again, that cry has been there for a couple of years by retailers that have been going out of business and continue to go out of business because cigarettes are available at many, many places other than those regular legal outlets.

## 0940

The legislation's other proposed measures, such as legislated package sizes and package warnings, that differ from federal standards will not be effective and will put even more pressure on the legitimate market. In our opinion, and obviously we're not specialists or experts in the fields of advertising and promotion and those types of things, but we are ordinary Ontario and Canadian citizens, and in this particular province in this particular country, if you've been alive the last five years and can hear and see, I don't think there's a person around who isn't aware of the so-called tobacco hazards. Whether you



put it in five-inch letters, in brown packages, in our opinion it will make no iota of difference as far as consumption.

It should be pointed out that tobacco remains a legal product. Such measures as this proposed act add to a résumé of social engineering measures which, as the Mackenzie report points out, are partly to blame for the existence of a black market. I think we all know that year after year of increased taxes has led to this underground economy, crime and so on.

The point is clear: A control act cannot work if the marketplace is out of control. Persuasion and education could reach the desired results much more effectively than dictatorial methods of social engineering. I think we here were all teenagers once upon a time too. We all love the challenge of the things we're not supposed to do. When Dad says, "Don't smoke, don't drink, don't do this, don't do that," you know darned well, we all tried it; they will all try it. The more we dictate to our teenagers, our young kids—I'm not so sure if that's the right answer.

The underground trade also has serious economic implications for our 1,500 producers. Ontario accounts for 90% of Canada's tobacco growing industry, with a farm gate value of over \$300 million and an economic spinoff estimated at \$2.4 billion in this province. Contraband, what we lost, cost us as growers last year an estimated \$25 million, because contraband does not necessarily have Canadian tobacco in it. So it's a total loss to us as growers and as farmers. Increasing restrictions threaten the future of these producers. Canadian smokers are no longer smoking Canadian product, and this is directly affecting our production levels, as I have stated. It is estimated that 45% of contraband seizures since 1992 have been of foreign manufacture, i.e., the UK, the United States, China, Mexico and so on. That's 45% of contraband seizures. You've heard a lot about the three manufacturers in the last couple of weeks, but very little was said about this part of it and it's growing tremendously.

Our producers are also under pressure from the criminal element. We have witnessed an increase in theft of raw product from our farms. Our producers are also being approached to sell leaf outside our regulated tobacco marketing structure; in fact, to the tune that we've asked both the Ministry of Agriculture and Food and Agriculture Canada to supply us with investigating police services, whatever they're called, on a full-time basis. We've had no response to this point, but we do need one or two people on a full-time basis to deal with this problem.

Agriculture in Ontario without tobacco would have a major void. Alternate crops have been the focus of concentrated scientific attention and are simply not feasible. There are success stories, but more failures. The environmental, social and economic sustainability of the regions involved in tobacco production would be drawn into serious question without this significant crop. In any language, a \$300-million farm gate is still big dollars.

Again, thank you for the opportunity for input, and we'd be happy to answer any questions you may have.

**Mr George Dadamo (Windsor-Sandwich):** Always comprehensive, always more than what you need to give to us, and we appreciate that. Thank you very much. I

guess you're caught between a rock and a hard place. You're running a business where you're trying to make money. You understand that smoking cigarettes can become very hazardous to one's health. This government is struggling to pass legislation which will ban the vending machines, which will keep cigarettes away from minors, because you know, I know, the committee knows that if they don't take up smoking in their early years, before 19 or 20 years of age, likely they're not going to smoke because perhaps they will know that it's going to be bad for them and they won't do it. Should we perhaps take them away from many stores, from the corner stores, and put it in the hands of government stores, as they do in some European countries? I understand that in places like Italy it seems to run okay.

**Mr Bouw:** In Italy they also have a huge smuggling problem. I think it's the result of exactly what you're talking about. If you were to do what you're suggesting, you would create an even greater underground problem. You really would.

**Mr Dadamo:** I think it must be said that the downside to selling them in government stores, and it happened in Italy last year, was the fact that if they go on strike, then they can't get cigarettes, thus the contraband coming through the borders. I'm sure that you get all sorts of things that happen. But what do we do to take it away from youth? We don't want kids smoking.

**Mr Bouw:** Obviously we haven't seen any details, but we don't like how they're sourcing the money, with the initiative that the federal government has taken and the announcements made by the Prime Minister that let them take \$200 million away from the manufacturers. We don't agree with how they're getting the money, but what he's going to use it for, for educational purposes, we feel that is the right thing to do. We support that; we always have. Ultimately, if at the end of the day the message that education puts forward doesn't work, I'd suggest then that the educators' information isn't the proper information; it's not working. My suggestion would be to change the information, whatever those packages say today, and I'm not privy to that.

**Mr Dadamo:** Should we cease selling them in pharmacies?

**Mr Bouw:** No, I don't believe so at all. We think the control in drugstores, pharmacies, is greater than in any other outlet. When you go to the local drugstore and you see these people in little white gowns standing around, it has much more of an impact on young kids or anybody than the guy who's standing with a dirty old sweater behind the counter in a Mac's Milk store at the corner. The drugstore lives under different criteria. Leaving cigarettes in the drugstore, as far as controlling is controlled, will do a much better job than any other place.

**Mr Dadamo:** I just don't get it. I'll be very brief. Medicine and cigarettes, I don't see how they mix together: Trying to make people well, and selling cigarettes, which doesn't make people well.

**Mr Bouw:** I think there are a lot of arguments against that. I mean, over here they're selling drugs, here they're selling cigarettes and in the middle they sell Nicorette.

**Mr Dalton McGuinty (Ottawa South):** Thank you, gentlemen, for your presentation. I'm not here, and I

don't think anybody should be here, intent on assigning blame. I think the important thing here is for all of us to assume some responsibility. Tell me a bit more. What does \$300-million farm gate value mean?

**Mr Bouw:** That's what I as a producer, when I sell my bushel of apples—in our case tobacco—get when I take it to my marketplace.

**Mr McGuinty:** So you're telling me the industry in Ontario annually sells its product for \$300 million?

**Mr Bouw:** Yes. There's no value added or anything. That's what that merely means: it's just off the farm gate.

**Mr McGuinty:** Are there any government assistance programs right now for tobacco growers?

**Mr Bouw:** Right now? I don't think so.

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**Mr McGuinty:** All right. Is there any assistance in order to help you diversify?

**Mr Bouw:** There was some of that and then there was actually a program announced, it would be three years ago now I guess, but it never was put together. I think it was \$33 million. It was for Redux. I don't know if you're familiar with that term. It was an exit program which we had for about four years. A lot of tobacco farmers left the industry. That was one side. The other side was AIE, alternative initiative enterprise. There have been dollars spent on that over the years. Those programs ran out. A new one was announced by Mr Buchanan. This will be the third year I think.

**Mr Larry O'Connor (Durham-York):** The buyout or crop diversification? Which one are you talking about?

**Mr Bouw:** It was a combination.

**Mr McGuinty:** So that program is still in place now?

**Mr Bouw:** No, it never was put together. I don't think anybody ever went to treasury board.

**Mr O'Connor:** Were there any takers?

**Mr Bouw:** There were takers—oh, go ahead.

**Mr McGuinty:** I was going to say I think it's important, if we as legislators are intent on addressing this problem, that we provide some positive incentive to get those who happen to be growing tobacco into another area. So there's no money there today, you're telling me.

**Mr Bouw:** I don't know what happened to that money, to tell you the truth. It never was taken away but it was never put there. I mean, it's one of those government things: "Here's \$33 million," but nothing—

**The Vice-Chair:** A proposal.

**Mr Bouw:** You could call it that, but in the last budget we were cut \$3 million. Like, when they did all the budget cuts for Agriculture, they took \$3 million out of that program, although we never really had the money.

**Mr McGuinty:** If I'm a tobacco farmer, what do I need to get into another line of work, another crop? What is it going to take?

**Mr Bouw:** A lot of us have tried to get into other crops; ie, ginseng. There's a lot of ginseng in our area.

**Mrs Karen Haslam (Perth):** Have you tried nursery stock? Sorry, Mr Chair.

**Mr Bouw:** I was going to answer this gentleman about ginseng. There have been a lot of acres. Actually, ginseng's been grown in our area for about 80 years, on a very small scale. Since the downturn of the tobacco industry, a lot of tobacco farmers got into ginseng and it's a pretty lucrative business, although expensive to get

into. However, I know now, this year, there are already some crops that are not sold.

**Mr McGuinty:** Is this the root, the herb?

**Mr Bouw:** Yes.

**Mr McGuinty:** All right. I've heard that the market has fallen out on that.

**Mr Bouw:** Exactly; that's my point. It was successful, but like anything else, if we all of a sudden use all those thousands of acres to get into all these other crops that other people were growing—the vegetable industry was not very pleased with tobacco farmers in about 1985-86, because we were going to grow peppers and tomatoes, and then you come here to the Toronto food terminal and you were very quickly turned back. So you were forced to cut your price, and then you upset everybody, or take the product back home and dump it.

The government said, "Go find something new." A lot of things were tried; ie, rubber plants. In this climate? That didn't work. Both research stations spent about \$1 million, by the way, on that. I couldn't understand why both of them had to do it, but they did. That wasn't successful. We had a peanut cooperative. That wasn't successful. There is still a peanut plant in existence. It happens to be about a mile down the road from me, where I live, but the guy is totally vertically integrated and makes it work. As far as peanut farming goes, the US just brings them in here much, much cheaper than what we can afford to grow them for. That didn't work. The hay co-op didn't work. The sweet potato co-op didn't work. Tomato, SOCT, you probably remember that one. That one didn't work.

There are some success stories. There's a garlic association that grows 100 acres of garlic. That's enough for the whole country; we don't need any more garlic. There are some people growing dried flowers. If you grow five acres of dried flowers, you don't need any more. And it goes on.

Now there's a request in, I understand, to grow hemp.

**Mrs Dianne Cunningham (London North):** What?

**Mr Bouw:** Hemp, marijuana.

**Mrs Haslam:** It's not rope, Dianne. They don't grow rope.

**The Vice-Chair:** Excuse me. Now that hemp has been mentioned, and I understand there are going to be two or three licensed, maybe—is it the federal government?—I think it should be explained that the fibre is a very, very good type of fibre that's used for many purposes, very strong, indestructible, and also the seed that's produced is very, very, very low in narcotic. Sorry, just for information.

**Mr McGuinty:** Just one final question, because I'm sure my colleagues have some as well. Some are easier to buy out than others. Is that at all feasible if I'm a farmer who's growing tobacco? If it is, what does it cost? How do we assess that value?

**Mr Bouw:** I guess, to go back a number of years when the onslaught really first came, that's what the tobacco farmers said then, "If that's the case, then give us \$2 a pound for our quota and we'll say goodbye," and of course that never happened. Personally, I don't want to get out of tobacco farming. It's what I do; it's what I like to do. It's a legal product still. I have a problem with



this, and I guess I'll say it, hypocritical attitude towards our industry: on the one hand, "Give me all these tax dollars," and on the other hand, "Get rid of you."

**Mr McGuinty:** I agree with you, yes.

**Mr Bouw:** Ban the damn stuff or let us go on with our life.

**Mrs Cunningham:** I have two or three questions, actually. When you say that Ontario accounts for 90% of Canada's tobacco-growing industry, how much of the tobacco in Ontario is exported?

**Mr Bouw:** The ratio used to be 70% domestic, 30% export. Obviously we've had to change, so now it's about 50-50, give or take; it varies a little bit from year to year.

**Mrs Cunningham:** Is one of our greatest recipients the United Kingdom?

**Mr Bouw:** Yes.

**Mrs Cunningham:** Because over there many years ago they told me that they knew Ontario for tobacco and soybeans, so I always think of us in that regard.

I'm from southwest Ontario, London. I have a very large riding and spend a lot of time in the other ridings, for obvious reasons, and you don't have to convince me that the tobacco growers have tried alternative crops probably for the last 10 years. It's not new.

**Mr Bouw:** Yes, that's right.

**Mrs Cunningham:** My kids have all worked in it to pay their way through school. I'm very grateful for that. I'm happy to know that you export a lot because I guess my concern is the health of Ontario, and I know you care about that too.

I'm interested, though, because we've had other instances where legislation has been applied in the last few years because persuasion and education hasn't worked and we've been told, certainly by the educators, that they haven't been successful in schools. You know that if you talk to anybody in Ontario who tells you not to smoke, it's often a seven-year-old or a five-year-old. It's the success of the early education programs. I think that's why this committee is struggling with the work we've got to do right now. I was very interested in your comments on pharmacists. I happen to agree with you because I think that they are the ones who in fact do ask the questions. At least, we found that out in London. The secondary school students have done a little survey in the last couple of weeks and that's what they've told us, at least in three of our high schools. There at least you're quite correct.

We've been told that a licence would be very important to stop selling tobacco to minors. That's what we're after here. We've been pretty well convinced by a lot of the witnesses that we shouldn't be focusing on people who want to kill themselves but that we should be focusing on people we don't want to smoke. We thought, at least the advice we've been getting is, that licences would be helpful. This is a most interesting brief. You've obviously had some influence elsewhere, but why do you feel so strongly?

**Mr Bouw:** I guess we're just looking at cost. What are we doing to people every day? With this tax, this licence, this requirement, what are we doing to people? Let them make a living.

**Mrs Cunningham:** So you wouldn't like it if we sold them an LCBO outlet.

**Mr Bouw:** Oh, no.

**Mrs Cunningham:** Well, it was a thought.

**Mr Gilvesy:** Mrs Cunningham, what licence does an illegal retailer have?

**Mrs Cunningham:** You're right. We know that, but there are some of us here who are prepared to say this is an illegal product in Ontario.

**Mr Bouw:** Then it becomes a different issue.

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**Mrs Cunningham:** That's right, and then you'd have something to say to us about that.

I can only speak for myself here. I'm finding this to be a very difficult issue, so I want you to know that I'm not just sitting here being facetious with what you've said. Your work in this province has been important to the economy of this province, and we know that. We're trying to find a solution, but we know that education isn't enough. That's our problem.

**Mr Bouw:** As I said before, I'm not an educator at all. I'm not a very smart person; I'm just a farmer.

**Mrs Cunningham:** It's called street sense, which a lot of people are missing, and common sense, which they're missing more.

**Interjection:** Field sense.

**Mrs Cunningham:** Yes, field sense.

**Mr Bouw:** Maybe the programs that are being used aren't valid or proper; I don't know that. But yes, common sense has a lot to do with it.

**Mrs Cunningham:** I'm not going to ask you how you grow dried flowers, but it crossed my mind. Do you want to tell us?

**Mr Bouw:** My wife does that.

**Mrs Cunningham:** I love dried flowers. I didn't know you grew them. I just turn my live flowers upside-down.

**Mr David Winninger (London South):** Thanks for your presentation. We're hearing that the percentage of smuggled cigarettes in Quebec is as high as 60% and in Ontario somewhere around 35%. This problem has really mounted over the past few years.

I'm just wondering what steps the marketing board might have taken to combat this problem, which obviously imperils your own industry.

**Mr Bouw:** I guess I mentioned at some point earlier that we've asked for more enforcement. We have several files. We've worked with both the Ontario Ministry of Agriculture and Food inspector, David Sloman, and also an RCMP detachment out of Woodstock, Scott Stevenson. Last year we even offered a \$10,000 reward.

Yes, there have been a few arrests and what have you, but we're just too small to tackle the big problem. It takes total and dedicated enforcement to do anything about this problem.

The federal government, it appears, has recognized it now. We're still not convinced, unless they're sincere, that enforcement will work. We're still saying we're not sure that will work, because our borders are huge. It makes you wonder sometimes if law enforcement itself—I mean, they smoke too, some of them. I know they've been told they shouldn't buy contraband cigarettes, but they do anyway. So how dedicated is the dedication to stopping it? That's my question sometimes.

**Mr Winninger:** So you're answering the question

with a question. That's very political.

**The Vice-Chair:** The parliamentary assistant has a point he wishes to make.

**Mr O'Connor:** My understanding was that there was a joint committee, either established or going to be established, and I'm surprised that you wouldn't know about it. My understanding was that it was with the ministries of Labour and Agriculture and Food around the economic review. Is there such a committee and are you part of that?

**Mr Bouw:** Yes.

**Mr Gilvesy:** What is your point on that, sir?

**Mr O'Connor:** My understanding, in questions from Mr McGuinty, was there seemed to be no coordination happening here. I understood that this committee was taking place, and I thought you might be part of that.

**Mr Bouw:** We're paying to have the study done.

**Mr O'Connor:** And you're part of that committee.

**Mr Gilvesy:** Yes, we're a stakeholder in that project.

**Mr Bouw:** We're not receiving any money.

**Mr O'Connor:** No, but you're part of that, though.

**Mr Noble Villeneuve (S-D-G & East Grenville):** Thank you very much for coming and presenting your case. I come from that part of Ontario where Bill 119 to ban legal cigarettes anywhere would not really be very necessary, the way things are going.

However, Bill 119 is a fact of life. We will likely support it, except for that one area where it's causing pharmacists and pharmacies a great deal of concern in that we may be in a situation where some of the larger pharmacies will find a way around the legislation. Those that don't will simply be promoting more of what we have in eastern Ontario, which is the illegal pipeline of tobacco and what have you.

With the \$8-a-carton surcharge, is it—

**Mr Bouw:** Export tax, yes.

**Mr Villeneuve:** —export tax—how does that affect your business pertaining to how things have happened in the past? I'm sorry I wasn't here for your presentation; I was at another 8:30 meeting this morning. But I would like your perspective in a nutshell as to what you see happening to people who earn their living from growing tobacco, which is a legal crop. Some people may not agree that it should be legal, but it is very much legal. It's been a pretty good milk cow for the government.

**Mr Bouw:** Yes, the \$8 export tax that was put on by the federal government not too long ago, February 9, I guess it was, is a little bit different from the last time. However, it'll be exactly the same as the last time if the province of Ontario doesn't roll its taxes back.

The reason I say that is, when the \$8 tax was put on two years ago, it really created a lot of these problems that we have today, the 22 new brands of cigarettes that showed up at our borders after that—22 new brands showed up in two weeks. That's what created a lot of this stuff. I know there's some misinformation about how the \$8 export tax worked in that six- or seven-week period, because what the statistics don't show is there was no tobacco shipped for that period of time, period.

**Mr Villeneuve:** No revenue for the government.

**Mr Bouw:** That's why it showed it worked. The simple case was that manufacturers were under, really, the restraint of the law of the government and were trying

to work out arrangements, really, to come to some kind of understanding about this \$8 tax, that it wasn't feasible. So they shipped no tobacco, no product for six weeks. That's why the stats show that. Unfortunately, a lot of people out there who don't understand this misuse that information.

However, we did manage to get that \$8 rolled back. It was a bigger problem then because of the bigger price gap between the US and ourselves. With the move that Quebec has made, lowering the cost of a carton of cigarettes to \$23—and you can buy contraband for \$18 or \$20—you take the problem away. But Ontario has to follow suit to bring its price down to that. Once they do that, the \$8 is not an issue, at least in the short term.

Where we do take issue with the \$8 tax, however, is, we're an exporting country. I mean, just the climate of putting a tax on a product you export—we're an exporting country. What kind of signal do we send to the rest of the world? What will it be next, aside from the issue itself? It's dead wrong.

**The Vice-Chair:** Mr Bouw, Mr Gilvesy, thank you for your presentation and the information.

ALNASIR MOOLANI

**Mr Alnasir Moolani:** Thank you for this opportunity to make a presentation to you today. My name is Alnasir Moolani and I'm a practising pharmacist and owner of Heart Lake IDA Discount Drugs, which is located at 230 Sandalwood Parkway in Brampton. I have been the owner of this pharmacy since 1986. I'm still indebted to my bank and suppliers for moneys in excess of \$100,000. I presently have 10 employees in my store. I am one of the approximately 1,400 retailer pharmacies in the province that sell tobacco.

In June 1991, when the Ontario College of Pharmacists took a vote to remove tobacco sales from pharmacies, I was, like so many of my colleagues, disappointed with the college's decision. When I was contacted by the Committee of Independent Pharmacists to join them and take a position against the college, I agreed to do so.

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I think it is well known how our profession in fact reacted to the precipitous and irresponsible way in which the college members voted on the tobacco issue. When the elections were held two months later in August 1991, eight college members who voted for tobacco removal were themselves voted out of office. The college president himself was not re-elected. So the college representation today is very different from the college of 1992.

The mandate of the college is to "serve and protect the interests of the public." No one has explained to us how the public interest will be served by closing down pharmacies.

Just to give you an idea where our profession really stands on this issue, when the Ontario Pharmacists' Association held a referendum on this issue last year, 62% of our membership voted to leave tobacco in drugstores. So please appreciate that we are a profession very much divided about tobacco in drugstores.

However, there should be no doubt about pharmacists' commitment to discouraging young people from smoking. We support the legislation about making it more difficult for minors to purchase tobacco. In fact, we say that if the legislation did not contain subsection 4(2), this legislation



would have been passed by the government immediately in January 1993. Instead, you've taken a good piece of legislation and muddled the waters.

I would like to tell you the environment in which I operate. In my small shopping mall, I have one other vendor who sells tobacco. There's a Mac's Milk only five minutes away. They also sell many of the products that have been traditionally sold in pharmacies, like health and beauty aids, cosmetic items and so on. Across the parking lot from my store, literally less than a block away, is Heart Lake Town Centre. In that mall is my major competition, a Shoppers Drug Mart. Because of their massive buying power, their selling prices are often lower than the cost price I pay for some of my products. There are a number of gas stations in the area and all of them sell cigarettes.

In the Heart Lake centre, there are four or five other vendors who sell tobacco. In that centre is an A&P food supermarket, which also sells my core products at cheaper prices than what I pay for them. Just to add to my problems, not far from me is Hy and Zel's and perhaps soon the Wal-Mart chain. For your information, Wal-Mart has been found guilty on a number of occasions in the US of predatory pricing policies. Basically, they go into a town and literally wipe out the local competitors. They are a massive tank getting ready to go into battle.

Until a few years ago, pharmacies were among just a few stores that were open on Sundays. At my pharmacy, we used to do a fair amount of business on Sundays. But now, with all the retailers open on Sundays, our revenue on Sundays has dropped by almost 50%—literally a 50% drop. Over a year, this amounts to a fair reduction in revenue, but my overheads remain the same. I have to pay the same hydro, rent, cashiers' salaries etc.

A second major impact has been the ODB cutbacks. Now, I realize that all government programs have been cut back. I am a taxpayer and I fully recognize the intense financial pressures facing government today. But please appreciate what has happened to my profession. Unilaterally and without negotiation, the Ministry of Health has drastically reduced our remuneration for providing professional services by removing many over-the-counter drugs from the formulary. The government has eliminated the professional fee on many other drugs, and in terms of the social contract negotiations our professional fee on ODB prescriptions was rolled back 61 cents. By the way, as I'm sure you're all aware by now, we had not received a fee increase since June 1990. Last year we were faced with government Bills 29 and 81, which, although they never went through, have already conditioned us that the Ministry of Health wants to find ways to cut even more money from the ODB plan.

The Ministry of Health effectively has told us that we can no longer rely on the fee to sustain our businesses and that we should rely more on our front shop sales, and then you come along and tell us that we should not sell tobacco, which represents about 20% of my front store sales. Then there are of course the complementary sales. A person buying tobacco will also buy many other items that my competition aggressively sells. Believe me, if there was another product that generated 20% of sales, I would have introduced it years ago. So would the other

drugstores. So what you see here today is a small independent community pharmacist desperately trying to make a living and providing employment for 10 other employees. Bear in mind also that I have a lease with its rental based on my sales of tobacco. Here I am shooting arrows at the Wal-Mart tanks, the mail order pharmacies, some of whom are being funded by the New Brunswick government, and I find my own government literally taking arrows out of my quiver. How can I possibly survive with such a piece of discriminatory legislation?

The Committee of Independent Pharmacists commissioned Coopers and Lybrand to conduct an economic impact study, and I'm sure you've already heard the results of their findings. They predicted that about 110 pharmacies will go out of business. Well, ladies and gentlemen, you're looking at one of those.

I am not in a medical centre. I don't have any doctors above my store feeding prescriptions to me. I rely solely on the community, and I try and provide them with all their needs.

In the end, what would you have gained? Less people smoking? You know that won't happen. In fact, by taking it out of drugstores, you will be moving the smoker to less responsible retailers who don't always sell legitimate tobacco and who often don't enforce the age restrictions. In fact, they constantly violate the law. Nor do they pay taxes. We enforce the age restriction so strictly that word has gotten around and I don't get any teenagers coming to the store attempting to buy cigarettes.

I have often heard that it is inconsistent for a pharmacist to sell tobacco. I agree, but pharmacies are not only selling medications and prescriptions. A drugstore today sells a multitude of products. We are in the unique position of being both retailers as well as professionals. In the same way that the federal and the provincial governments raise billions of dollars in tobacco taxes and you have come to rely on tobacco revenues to help your budgets, so have we. You raise your revenues through questionable means, for example, casinos. They have negative impacts on society, yet the government proceeds with more casinos.

I repeat again, please don't punish drugstores, which are the most responsible tobacco vendors in the marketplace. After all, we are accustomed to selling dangerous drugs. We know the implications of selling hazardous products.

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I'm sure we all know, in our heart of hearts, or should I say lung of lungs, that tobacco consumption is not going to be reduced by taking it out of drugstores. It may in fact increase consumption due to the fact that smokers will obtain their cigarettes through cheaper contraband sources.

Then, one might ask, why are retail pharmacies being singled out? Why? I urge all of you to think deep. It's not fair to me or my employees.

This controversy has a lot of do with the rights of retailers to sell legal products. We all know cholesterol is a major contributing factor to heart disease. Is the government going to step in and dictate to restaurants as to what kind of food they serve? It looks like McDonald's and Harvey's may have to stop selling

hamburgers, as they are a major contributing factor to this problem.

I honestly predict that if your legislation goes through with paragraph 4(2)8, I will be out of business within 12 months after your legislation takes effect, and my 10 employees, who are presently gainfully employed at the Heart Lake IDA Discount Drug store, will be on the government's payroll, UIC, and I for one will have lost all my equity in the business and my life savings.

Please, I urge you to reconsider your position. Thank you again for your patience. I hope I keep my patients. Thank you very much for listening.

**Mrs Haslam:** How long have you had your business?

**Mr Moolani:** Since 1986. I've been a pharmacist since 1977.

**Mrs Haslam:** There are a number of things in your presentation that do not ring with what other people have said around some of your facts. I will look at a couple of them, and then I maybe have a question or two. It's a long report and I'd like to go through that report.

You said, "I think it is well known how our profession in fact reacted to the precipitous and irresponsible way in which the college members voted on the tobacco issue." I don't believe your college feels the same way. You say that 62% of your membership voted to leave tobacco in the drugstores. Actually, the—

**Mr Moolani:** The OPA.

**Mrs Haslam:** No, actually, that isn't what it said. It didn't say, "Leave it in." What 62% agreed to was voluntary removal. So I'm sorry, but you're wrong there.

**Mr Moolani:** They didn't say to remove it from drugstores.

**Mrs Haslam:** It said voluntarily remove. You said 62% voted to leave tobacco in drugstores.

**Mr Moolani:** They did not say to remove it from drugstores. That's what I'm trying to clarify.

**Mrs Haslam:** It was the voluntary part that—

**Mr Moolani:** Right. It should be left up to the pharmacist so they can make the decision, but not be legislated by—

**The Vice-Chair:** I'm sorry. We need one person speaking. Mrs Haslam, would you make your comments and then we'll have a response.

**Mrs Haslam:** The other thing I wanted to mention was that the College of Pharmacists came in. You talk about what happened and overturning them and getting them out of office. We asked them questions on that, and it became very clear that it was an ongoing process within the college and that in June 1989 they adopted a policy of disapproval of the sale of tobacco products, that in October 1990 they had a motion about this put forward that passed, that they had a task force that came forward and looked at this problem in June 1991, that the report was approved at that time, looking at the amendment dealing with pharmacists respecting tobacco. You talk about August. In January 1993 the ministry put out a discussion paper. The Ontario College of Pharmacists affirmed its policy position—this is 1993—respecting the elimination of tobacco products in pharmacies, and when they presented to us this month, the college concurs with the inclusion of pharmacies as designated places for the purpose of the bill. I asked them about that and they said, "No, this is the position of the College of Pharmacists."

That was on February 10.

The faculty of pharmacy came in from the university. They said it is absolutely incompatible for pharmacies, as health facilities, to sell tobacco. That's the faculty of pharmacy. The graduating class of the faculty of pharmacy came in and said, "We're pharmacists, that's what you're teaching us, and we agree with this bill and that it shouldn't be sold."

The medical affairs chair of the Canadian Cancer Society put it succinctly, "This is a bill which shows foresight as a piece of legislation which is about health and not economics, about saving people's lives and not protecting the incomes of individuals or corporations."

So that's what this committee is left with. We have to look at the health issues, and it's something—

**The Vice-Chair:** Ms Haslam, is there a question?

**Mr Moolani:** Can I respond to this barrage of statements?

**Mrs Haslam:** I would like to ask about the lease. On page 8 of your presentation you say, "I have a lease with its rental based on my sales of tobacco." Is this a regulated part of your lease? Is this something that is written into your lease?

**Mr Moolani:** The lease states that it'll be based on general sales. That will obviously be a state of contention later on if this thing does go through.

Vice-Chair, can I just respond to a couple of statements Ms Haslam just made with regard to us carrying tobacco? You may say all those statements, but on the other hand, you do not remunerate us as health professionals. You allow us a fee of \$5. An average pharmacy may do about 60 to 70 prescriptions a day. Do your math. How can you afford to pay rent plus the salaries plus the overhead? You cannot have it both ways.

**Mrs Haslam:** Is there a change coming to that? I was understanding there were some discussions around consultation being covered under the program.

**Mr Moolani:** Changes may come, may not come, talk may be here and may not be there, but the point is that as it stands today you do not remunerate us enough to take the other side of the coin away. Do that, and we'll be glad to do that.

**Mr McGuinty:** I really don't have a question, just a comment. I think there's obviously a tremendous controversy among pharmacists as to whether or not they want to ban tobacco sales within their stores. I think the fact that speaks loudest for me is that out of 2,200 pharmacies that are operating in the province, 1,400 today are selling tobacco products. Let's remove the evil empire from that, Shoppers Drug Mart. There are about 300 of them. So we've got 1,100 out of 2,200 that are selling tobacco products, discounting Shoppers.

**Mr Moolani:** That's right.

**Mr McGuinty:** It still seems to me it's a major source of controversy. That's why I am befuddled and confused by the various presentations being made by pharmacists, and I think the general rule is that if we don't have some kind of consensus, we shouldn't act.

**Mr Moolani:** Absolutely. I think it should be left to the pharmacists to make their own decisions.

**Mrs Cunningham:** I very much appreciate your presentation. I think sometimes it's very difficult to come before a committee of this Legislative Assembly and



make points you know most members won't agree with. So I admire you, because I really think one of the downfalls of the legislative process is that we draw up legislation such as this without having the public hearings first around ideas.

**Mr Moolani:** Absolutely.

**Mrs Haslam:** That's not true; we had that.

**The Vice-Chair:** Do you have a question?

**Mrs Cunningham:** No, I'm not speaking about this legislation. If you did it, great. I wasn't part of any public hearings before the legislation came up—in this building. That's where I'm talking about, in this building.

As far as the pharmacies go, you've got your own problems with your own association. I'm very much involved with people at universities and young students, who are idealistic, and when they get out in the real world they too will have a mortgage and will change their minds, I can assure you. So I appreciate your point of view. I'm looking for good information and yours is one small piece, meaning your role and what you sell.

What I'm interested in is, what extent do you go to to make certain that people who buy tobacco in your store are not under the age right now of 18 and, with this law, 19? What extent do you go to? That's what we're interested in here: stopping the use of tobacco by minors.

1030

**Mr Moolani:** I'm glad you raised that point. Every member of staff, every single one, has been trained thoroughly, and I repeatedly reinforce this point about selling to minors to the point where I've told them: "You do that and I don't want to have you in my store at all. In fact, it's an offence."

I've gone so far that I do not get teenagers coming to my store. In fact, I've lost revenue from that lunchtime traffic that we used to have, teenagers coming into the store. I don't get a single teenager coming in. They all go next door to the convenience store and farther, elsewhere, wherever they go. In fact, I have lost business as a result of enforcing the policy but I'm prepared to live with that because it's something that has to be enforced thoroughly. Every member of my staff does that without question.

**The Vice-Chair:** Thank you for your presentation. We appreciate you coming before the committee.

#### COALITION FOR A SMOKE-FREE LINDSAY

**Dr Peter Petroseniak:** My name is Peter Petroseniak. I'm a physician in Lindsay and I happen to be the chair of this organization, Coalition for a Smoke-Free Lindsay.

I really do appreciate your giving me time to come down here and speak to you. I've been making a lot of presentations in Lindsay but it gives me a sense of awe to come down here to a legislative committee at Queen's Park and make this presentation on behalf of the Coalition for a Smoke-Free Lindsay.

I know you have heard a lot of statistics here from OCAT and other health organizations relating to what the reasons for enacting this sort of legislation are, and perhaps even something stronger, and I don't want to go through all that, although probably I should say that this is a major killer and therefore is a public health issue and therefore should be dealt with on a province-wide basis and therefore this legislation, at least, needs to be brought in. What I really want to do is bring out a perspective from a small town and perhaps share some experiences

from our situation where I think that enacting this sort of legislation would be very useful for us and I think for other communities like us around the province.

The Coalition for a Smoke-Free Lindsay is an association of groups that have formed in Lindsay to try to promote some local municipal bylaws. We represent The Lung Association, the Canadian Cancer Society, the Heart and Stroke Foundation of Ontario, our local chapters, interested individuals, some physicians, and so forth and we've received support from our local physician groups and other health organizations to try to help adopt these sorts of bylaws in Lindsay.

There are three bylaws on the books and it's all very apropos that it's all happening at around this time. That's why I thought it would be wise of me to come down and share some of these things while Bill 119 is being discussed here, because Bill 119 is constantly invoked by a lot of people, and they're particularly the people who are opposed to us because they feel that the province is doing all this work to bring this in. So I would hope that what is in here at least goes through, and perhaps there are a few things that may need to be brought in even stronger.

The three bylaws that we are proposing are a bylaw to regulate smoking in public places, which is addressed in section 6, I think it is; a regulation or bylaw to regulate smoking in workplaces, which I think already exists in provincial legislation but probably isn't strong enough; and also a bylaw to license the sale of tobacco in Lindsay. I see that Bill 119 deals with regulation of sales of tobacco, but I think also that it should be strengthened actually to license tobacco. We're promoting to license tobacco sales in Lindsay, but I think really what we should be doing is doing this across the province so everybody is equal and standard and universal. I think then things will be much better. It is this sort of perspective that I want to bring from our community.

The first thing I want to do also is commend the members of the Legislature in bringing forth this bill to the floor. As you know, the health coalitions and health organizations had a lot of concerns that this might not get to the floor, but it was a combination of both the government members and the opposition members that found the political will, the political courage, to bring it to the floor and I commend you all for that. I hope that it does get into place before spring, partly because I'd like to see this bill come through from a personal point of view but also because we are going to be dealing with this in committee in our own town over the next three months and it would be nice if this bill solved the problems for us.

It was just two days ago that I appeared before my own town council and I must say that the atmosphere was somewhat adversarial and probably was quite acrimonious. One of the problems is that this sort of scenario is being played over and over again all around the province, I'm sure, in many communities. Right now I think we counted up 74 communities which have some sort of bylaws and there are many other communities, there are small hamlets, villages, townships and there is a lot of energy being spent by groups like us trying to promote this. If we had one general piece of legislation that would do it, then it would save a lot of energy for us and also

make it standardized and universal. One of the problems is that there are a lot of places which never get it done because they're small townships and they don't have a lot of people to promote this sort of thing.

One of the things that was a recurring theme from the people who oppose this was from the business sector, and what they said was, "We do not want any more regulations"—there's a large body of opinion about that—"but if the province brings down Bill 119"—and they've become aware of that because we've been giving that information out—"or if the government brings up some type of tobacco legislation, then we will abide by it"—because obviously most people are law-abiding citizens and when it comes from a universal sort of place, if it comes down from Queen's Park, then it becomes a lot more palatable—"but let's not venture into uncharted waters." Because this is something new in Lindsay it becomes difficult to do, whereas in Toronto it's been done, and we've got bylaws that we've brought to our town council to show them what has been done. This is all from places like Ottawa and small towns like ours, Cobourg, Peterborough; this is all very new for Lindsay.

One of the problems that they say is that they're worried, the business people, about losing business to the surrounding communities. I think that this argument would be played over and over in every community where it starts until all the surrounding communities have gone smoke-free and then of course that argument is lost in the last community remaining. But in Lindsay, for instance, we're the only community that's considering it and there are townships around us and the businesses are saying, "Well, I'm a hairdresser and if I discontinue smoking in my hairdressing shop, they'll go to the next township over," the same thing that's being said of restaurants.

I think that section 9, which is the control of smoking in public places, is a good section but it could go a little further. I think it could take in restaurants. It should really take in all indoor public places, because when we look at the EPA report from 1992 from the United States, and I'm sure you're all aware of that, and some of the information from the 1986 Surgeon General's report, it shows that environmental tobacco smoke is harmful. If it is harmful then we should control it in public places, and that would include all public places; bingo halls especially are notorious, and a lot of other establishments.

The problem is that when we made our presentation we had people from Rotary come in opposition, saying, "We can't survive because if they won't come to Rotary in Lindsay," and this may indeed be the case, "they'll go to Ops township or the next township, Fenelon Falls and so forth." But if we had something that would say, "Let's do this across the province," and that isn't in Bill 119 yet but we would suggest and we would urge you to actually put those things in, bingo halls especially; I know that laundromats are in there and retail establishments, but let's make it a little stronger—if we had that across the whole province then that argument would be negated. Then they would feel more comfortable and I think a lot of people would buy into this much more. What I'm saying is, let's not have our little groups reinvent the wheel every time in each little municipality, but let's do

it across the board. I think that this standardization and universality is the most important thing.

**1040**

I also think that because it is an epidemic when it kills over 10,000 people—there are varying statistics—13,000 people in Ontario and so forth; it kills 33,000 people across Canada; 330,000 or 350,000 in the United States. That is truly an epidemic. When we had a problem with polio, diphtheria, tetanus, measles, mumps, German measles, all of these sort of things, we enacted legislation to say mandatory immunization is necessary, and that has actually made a tremendous difference to the incidence and therefore to the mortality/morbidity in these diseases. I think that really we should be doing the same thing with respect to tobacco, which is the number one killer. It kills a lot of people.

I wanted to also share with you some experiences as a practising physician. This relates to the sale of tobacco in pharmacies. I did listen to the witness just before me and it was very interesting. I must say I disagree, and I think this illustration, this observation, might just illustrate why I would disagree.

I have a patient who's an asthmatic, very asthmatic, with poor respiratory function and he also has heart disease. I've been after him for years to quit smoking. He's getting worse and worse. He comes to my office and he can hardly breathe but he's addicted to this drug. His wife also has heart disease and has just had a quadruple bypass. She has never smoked but she is definitely a victim of secondhand smoke. She admits it; her husband knows it. He came to my office—she was in hospital still—and he said to me: "I'm going to quit. I'm going to quit for my wife. I'm also going to quit because I can hardly breathe." He made a date and I said, "Come and see me a week later."

He came back to see me a week later and I asked him how it went. He said: "I really did well for most of that week but two days ago I went to the drugstore. I had to pick up my monthly prescriptions. As I was walking out, there was the counter with the tobacco sales. I saw it and I didn't want to buy any, but because it was there it was a reflex action. I've done this so many times." I can understand it because this is an addict; it's like sending an alcoholic to a liquor store. He bought his package of cigarettes, he walked out of there and he continued to smoke.

We're continuing to work together on this. But how ironic it is to me that here it is, he came for his lifesaving medications, his life-prolonging medications, because without these things like Ventolin, Theo-Dur—some of you will recognize some of these drugs—he could not be alive today. He went there for those medications; he came out with a package of cigarettes. Probably the substance, if he continues, will kill him.

This is not even children, and for children it is even worse. So I say we need to have this: Ban tobacco sales in pharmacies.

I belong to a group called Physicians for a Smoke-Free Canada and they've been working in the Ottawa region particularly to try to get pharmacies to stop selling cigarettes voluntarily in pharmacies. It has worked to some degree among the independents but it has not been



successful, and this is an ongoing campaign; it's not a negative campaign; it's a positive campaign to try to encourage people not to buy cigarettes at pharmacies that sell tobacco products, but it hasn't worked.

I have a little notation on my prescription that says, "I encourage you to buy your prescriptions at a smoke-free pharmacy." In Lindsay there are a few, but those are the independent ones. I've gone to each of our pharmacists; I know them all. It's a small town. They come together for our medical society meetings. I've said to them, "Could you ban cigarette sales in your pharmacy?" and they all agree with this, but the problem is some of them are bound by contracts with their franchisers or their outlet stores that govern them. The particular ones are Pharma Plus and Shoppers Drug Mart, the big ones, and Maxi Drug is another one.

Perhaps the most poignant illustration of this is the Shoppers Drug Mart scenario. These two gentlemen who own that store—it was a private independent store called Quinn's in the past—did not sell cigarettes in their store. Then they had reorganization, a financial, economic consideration, and they combined with or sold their interest or whatever it was that they did with Shoppers Drug Mart and they became Shoppers Drug Mart but they still are the owners, the managers of this store and they had to go and sell cigarettes. Although they themselves do not smoke, they do not want to sell cigarettes, they have to because that is part of their ability to buy with Shoppers Drug Mart. I think that is really the tragedy.

I say, with respect to the witness before me, I understand that. I'm quite sensitive to the business aspect of things. I'm a businessman myself. Because I'm a private practising physician, I understand what he's saying about decreased fees as a physician. I'm sure Mrs Haslam understands this as well. We all are under the gun and we all have felt that our remuneration has not been keeping up, but I think this really has to be dealt with as a public health issue and not primarily as an economic issue.

I think we have to be a bit more creative to find other ways of generating revenue, perhaps, in pharmacies or perhaps pharmacies will have to do that, but I think that selling tobacco in pharmacies is wrong. I also concur with the provision in there to ban vending machines. I think it's the same thing.

I'd just like to end by saying a few words about the provision of tobacco to persons under 19. I'm most impressed, from my practice, that most of my patients that are over 20 want to quit smoking. I would say that 90% of them want to quit smoking. The problem is they're addicted people who want to quit smoking, or the others are those that are dying, like that patient I just mentioned. Maybe he'll quit, but the problem is he has a high degree of morbidity already.

I would say that 95% of the people who started in the practice since I've been in practice, and it has been 13 years in my community, are teenagers. I speak to them before they actually start, and then they come in; they're 14 and they haven't started; they're 15 and they've tried a few; they're 16 and then they smoke half a pack, and 17 they're smoking a pack and by the time they're 20 they come in and they say, "I want to quit."

We have to do something to try to prevent those

people from starting. Who wants our grandchildren to smoke? Which one of us here would say, "I do want my children to smoke"? Even those who might be smokers—I'm not a smoker, obviously, but I think there would be very few of us who are smokers who would say, "I want my children to smoke."

If we don't want our children to smoke, then we have to provide some regulations, we have to provide some legislation, we have to provide some methods to say to people, "Let's not recruit those people into smoking," because I think if we do that, if we're successful with that—and I know there's a lot of difficulty with that—but if we're successful with that, then we will indeed perhaps bring in, within the next 10 years, maybe the next generation, a group of non-smokers.

I think we have to do that. I think that raising the age to 19 is absolutely necessary and I think strengthening this is absolutely necessary. I would say that probably this bill should be strengthened to make a provision for licensing. We're pushing that in Lindsay, but what we'd like to see is to have this across the board and then we don't have to do this in our little towns.

In general, that's my presentation. I do thank you very much for your patience in listening to me and I hope this helps to give a perspective from a small town.

**Mrs Haslam:** I just found it interesting when you talk about no fee increase since June 1990. Dianne and I looked at each other and said, "Well, neither have we."

**Dr Petrosoniak:** I'm not here to complain about that.

**Mrs Haslam:** No, no, I didn't—

**Dr Petrosoniak:** That might be another forum.

**Mrs Haslam:** It was just really funny that you said that, and we're all in the same boat now. I wanted to thank you, first of all, for your presentation, but I also wanted to thank you for not using the words "level playing field." I think we're all sick to death of hearing it. You talk about universality and standardization and I want to thank you for that.

You talk about the inoculation of children's disease; you're a practising physician. Do you think research will ever come up with an inoculation that we could give our children at a young, young age that would prevent them from starting smoking? Should we be looking at research into that area of medical research?

**Dr Petrosoniak:** It's an interesting thought, but I've never thought about it and just thinking from a purely scientific basis, I don't know how that would be done because, unless you introduce some sort of substance like Antabuse with respect to alcohol, how you'd do that, I don't know. I think really it is education.

**Mrs Haslam:** That's where we disagree—education. Both Ms Cunningham and I have been in the teaching profession and we know education is good, but it's not working as well as we would like to see it. Thank you.

**Mr McGuinty:** I have no question for you, sir, just to thank you for a very informative presentation. I thought your point was well taken with respect to the ongoing skirmishes throughout the province, the number of different battlegrounds and obviously we can play a role in eliminating that.

**Mrs Cunningham:** I also want to thank you. Obviously you're working very hard with your own commun-

ity and I encourage you in that regard. There's a lot of good information on what bylaws municipalities have enforced, and if you have difficulty getting it we'd be happy to help you. I'm from London, Ontario, so I do all the rural communities and I know what you're up against. I also think the smoke-free workplace legislation is nonsensical around ventilated areas; I was on the committee and voted against it for that reason.

We'll be supporting this legislation. My questioning is usually around how do we stop the sale of cigarettes to young people, because I agree with you that the addiction problem is the big one and we learned a lot on that from people like yourself in this committee. I really want to thank you and if we can help you with any of the things I've used as a member of the Lung Association for many, many years, we'd be happy to. Thanks for today.

**Dr Petrosioniak:** Thank you.

**Mr O'Connor:** I want to thank you for coming from Lindsay. I live over in Sunderland. In fact, my son was born over in Ross Memorial and it wasn't too long ago this winter when I had a little injury and was into Maxi Drug in Lindsay for a prescription. I appreciate all the hard work you're doing on this issue.

You know the government's very committed to this and we know there are a lot of people out there in the community who are working towards the cessation and what not. As a physician, then, I'd like to ask you—not me, you're the physician—is there a way we could help you in the cessation programs?

**Dr Petrosioniak:** There are a number of cessation programs now started up by groups like Physicians for a Smoke-Free Lindsay; there's a BC group. We use these in our practices. I've gone to a lot of seminars. Obviously, I'm interested in this and there are a number of things I do in my practice. I don't know what I could ask you at the moment. If there were, it would be—

**Mrs Cunningham:** You could make it illegal.

**Dr Petrosioniak:** You could make it illegal, yes, and perhaps that's really the way we have to go. I'm sure you've heard this statement before: If this product was introduced today it would never be legal. Perhaps we should look at it in reverse. Should we continue to make it legal? If it's used in the way it's supposed to be used it's a killer, at least causes morbidity and so we should perhaps look at it.

However, I understand the problem with prohibition. We've gone through this with smuggling cigarettes, we've gone through this with the prohibition of alcohol—way before my time—although there is a difference, perhaps, because alcohol, if used as directed, can be a perfectly safe substance. As a matter of fact, there's some evidence that it increases HDL cholesterol and so it may actually be a safe substance. It's not exactly the same, but maybe we could make it legal.

**Mr O'Connor:** Thank you. Mr Chair, I've got a copy of the press releases from yesterday from OCAT around some surveying and polling that it's done and I'd like to share that with the committee, just to table that before we adjourn to go to Ottawa. Thank you for coming from Lindsay. I appreciate that.

**Dr Petrosioniak:** Thank you very much.

**The Vice-Chair:** Thank you, doctor. If you notice

some of the members have left, it's because of a plane. We have a very short time. But thank you very much for coming forward with the presentation.

We will meet again at 3 pm this afternoon in Ottawa.

*The committee recessed at 1054 and resumed at 1501 in the Westin Hotel, Ottawa.*

DEREK ABDALLA

**Mr Derek Abdalla:** Good afternoon, ladies and gentlemen. Welcome to sunny, warm Ottawa. My name is Derek Abdalla and I appreciate the opportunity to speak to you today about Bill 119.

I'm a pharmacist and the owner of a Shoppers Drug Mart on Bank Street in the Walkley Centre here in Ottawa. As a retail pharmacist, I have all the business-related problems of any other retailer, plus additional problems unique to pharmacy. As a pharmacist, I differ from other retailers because of my professional training, health care role and position of public trust. Pharmacists must serve as part of the health care team. However, we must also be retailers and must generate revenues and profits. This places us right in the middle of this tobacco controversy.

I have to say right up front, I'm opposed to smoking. I'm a non-smoker. I lost my father to lung cancer; a heavy smoker. So I've suffered personally from the effects of this tobacco. For compassion's sake, and from my own perspective, we must do everything we can do to ensure that not one more young person starts smoking. However, I believe that a pharmacy ban is not the way to solve the problem. It will not make a hill of beans' difference if pharmacies do or do not sell tobacco. I'll return to this concept later.

Smokers must be educated, they must be counselled and options offered that are available for them in today's new pharmaceutical technology and other kinds of audiovisual technology. In this respect, pharmacies may in fact be the best place to sell tobacco. I'll repeat that. Pharmacies may be the best place to sell tobacco. A pharmacy ban will likewise do nothing to ensure that young people do not start smoking. Statistics show that teenagers do not buy tobacco in pharmacies. Taking it out of my store will not help achieve the goal that we all ultimately want to achieve.

My store is approximately 7,500 square feet. I presently employ over 70 people, and we're open every night until midnight. I sell tobacco, which makes up approximately 5% of my sales mix. To put those sales in perspective, it's roughly equivalent to my sales of paper goods or confection.

If I lose 5% of my sales overnight to a tobacco ban, I will obviously have to make up the loss in some fashion. Believe me, it's not easy, particularly in this economy, to replace such a significant sales loss. I will have to pare down my staff by at least an equivalent amount. Hopefully, I can do so by reducing part of the part-time hours, rather than by actual full-time layoffs. Even though tobacco makes up 5% of my sales, it's a low-maintenance product and it doesn't require a lot of staff to stock the shelves and sell the product. So in fact I may be reducing my staff relatively more for the other products that I sell.

I have a study that was done very recently by Coopers and Lybrand. I just received this today. You don't have



this but I can provide it for you. The statistics that Coopers and Lybrand came up with, and I'll focus on eastern Ontario, were that in eastern Ontario, there's a potential of 510 jobs on the line. They break it down into 127 full-time and 383 part-time jobs. They also have done an economic impact study which indicates that potentially 22 to 26 pharmacies in eastern Ontario might have to close.

So here I am, located in a strip mall. Across the street there's a gas bar and a convenience store. They both sell tobacco. The convenience store happens to be my chief competitor in my tobacco market. If legislation is passed, I will lose a lot more than 5% of my sales, the 5% that is tobacco. Many of the items that convenience stores sell are pain relievers, cough and cold remedies, muscle rubs and any number of other medicinal products that have non-pharmacy sales status. They are definitely competitors, not only in the tobacco market but in all those correlated markets and those OTC, over-the-counter, products I feel are best suited to sale in a pharmacy, not in a convenience store. What I'm saying is, losing the tobacco availability will draw people to those stores where they won't have the availability of a pharmacist consulting.

Proponents of a pharmacy ban often state that seeing tobacco in a drugstore sends a confusing message to the public. In a sense, they argue, the public thinks that pharmacists are endorsing its use. Where did this idea come from? Selling tobacco in a pharmacy will not influence young people to start smoking. I find the argument logically flawed and it does not reflect the reality of the drugstore industry today.

I have another paper that came out from Environics, Ontarians' Attitudes Toward Tobacco Sales in Pharmacies. I might note that this was done for the Ontario Campaign for Action on Tobacco—I could just put in brackets "the other guys." I'm just reading the results summary: "A majority of 67% of Ontarians consider pharmacies and drugstores in Ontario to be retail stores that sell a variety of products. Just 24%—less than a quarter—"see them as primarily and only a health care retailer."

The study also indicates that a large majority, 64%, nearly two thirds, say that a pharmacy's decision not to carry tobacco won't affect their decision to go to that pharmacy. That's almost two out of three people say that whether or not a pharmacy stocks tobacco won't change their decision to go to that pharmacy.

When you walk through a typical Shoppers Drug Mart or any other large retailer, you will see roughly 15,000 items, every little widget in the world. You'll see health and beauty aids, a large cosmetics section with lots of displays and manufacturers' promotional material. You'll pass a greeting cards section and a stationery section filled with bright coloured packages designed to draw your attention. I use things called clip strips to merchandise sundry gifts and my ends of aisles are always dedicated to promotional sale of such items as laundry detergent or soda pop. I'm painting a bright, active retailing business.

1510

At the front, in an eight-foot section, behind my cash

counter, where we display candy bars and magazines, you'll find the tobacco secluded away. This section is much less prominent than the other areas of my store. It is less influential on the customer than any of the other products that I sell, especially items such as cosmetics and confectionery.

The fastest-growing sector of retail pharmacy business in the last several years has been mass merchandising. We are very similar to other retailers in that the majority of purchases are made as a result of in-store decisions, and almost 40% of purchases are impulse items. Why am I coming from this direction? We need to survive with traffic builders. Tobacco products are definitely traffic builders and there are no other general merchandise items that can generate the sales per square foot that this category can. It's an important category of products that contributes to the viability of my store and the employment of my employees.

On the weekend, an article in the Financial Post talked about Wal-Mart. The Wal-Mart format is heavily emphasizing pharmacy and health and beauty aids, and that makes up a considerable part of its operation. The article described how Wal-Mart uses state-of-the-art technology to distribute its products, strong negotiations and profit-sharing to motivate its employees.

This is what pharmacy is also about today. It's about caring, professional advice and fast and friendly service. It's also about things like in-store satellite communications, point-of-sale purchases, automatic inventory control and state-of-the-art technology.

Pharmacy is no longer only a 1,500-square-foot corner shop with a soda fountain and public telephone. Not all pharmacies are located in medical clinics that have a captive market of doctors and where the majority of the business is prescriptions. Many pharmacies are as large as or even larger than my 7,500-square-foot pharmacy. Many sell a huge range of products as well as health care products. Many are like Zellers or Loblaws or Wal-Mart with a pharmacy as a small department within a huge supermarket or mass merchandising store.

How is it that young people will be influenced by the sale of tobacco in these retail facilities that happen to have a dispensary? Is it inconsistent for Zellers to sell tobacco? Will the consumer be confused if the tobacco is sold up front next to the CDs or pocketbooks or anything else? I think you would agree that the consumer would see no relationship between the CDs and the pocketbooks simply because they are sold in the same retail facility, and so it is in a 7,500-square-foot store such as mine. I might add that in the 7,500 square feet, the dispensary is 80 to 100 feet from the tobacco sales.

The stated intent of the legislation is to prohibit the sale of tobacco in any health care facility. The definition includes pharmacies and any retail establishment if a pharmacy is located within the establishment. What this committee fails to understand is that there are many different types of retail establishments that also have a pharmacy. A pharmacy is not always a drugstore and certainly there are many instances when defining the whole retail establishment as a health facility is absurd. The definition that is used here goes well beyond the stated intent.

Some pharmacies are just a pharmacy with little or no front shop and a heavy reliance on prescriptions and over-the-counter sales. Other pharmacies also have a drugstore component, much like my store. Still others, as I mentioned, like Zellers and Loblaws, have very small pharmacies within a huge mass merchandising or grocery store. They are not health facilities but the legislation lumps them together.

It looks to me as if the legislation is designed specifically to affect pharmacy operators like myself who operate pharmacies within large, standalone drugstores in the Shoppers Drug Mart format or the Pharma Plus format, the Loblaws format, the Zellers format.

We should be free to sell the products at our consumers demand and not to be constrained by the wishes of a vocal minority of pharmacists who freely choose not to sell tobacco. These same pharmacists are not available at 11:30 at night for patient counselling to help you with your child and your child's fever. They're not there. The total mix in my store allows us to remain for late-hour pharmacy service, and it helps finance the extended hours. The total mix finances the extended hours.

Even with the loss of my father, as my own personal experience with tobacco, I still believe it should be up to me to decide whether or not to sell it. It is not something that government should have the right to dictate. I could see the logic if the ban could produce some beneficial results to society. There will be no benefits whatsoever. No one will stop smoking as a result of a pharmacy ban.

Perhaps the best solution is to control the sale of tobacco through the Liquor Control Board of Ontario and Brewers Retail. In that way, although pharmacies would give up tobacco, we would not be at a competitive disadvantage to other retailers, and I think I mentioned the effect that lost tobacco sales on other parts of our retail business has.

It is clearly discriminatory to prohibit the sale of a legal product in one type of retail establishment while allowing its sale in others. If you instead allowed it to be sold by the LCBO, for example, and exclude all others, then it would be not so discriminatory.

I hope I have been able to help you understand the perspective of a pharmacist who also happens to be a retailer; the two-hat syndrome. Please recognize that the pharmacy ban does not take into account the retailers of the drug store industry in Canada, and with retailers such as Wal-Mart coming in, it is going to change even further.

I need to maintain flexibility. I have to provide my customers with the products that they demand and during the hours they require them. The pharmacy is the heart of my business, make no mistake about that. The pharmacy is the heart of my business, but it's not close to a 100% of my business. So I need to be able to sell other products to compete against other retailers. The pharmacy ban will be very discriminatory to me and to my staff as we try to survive in the 1990s.

In conclusion, I do not think that the consumer sees any relationship between the products sold in the front shop and the dispensary pharmaceutical care services I offer in the dispensary. Even though it may be inconsistent to you, it does not automatically follow that con-

sumers will perceive an inconsistency or be influenced by it. This pharmacy ban will achieve nothing except symbolism, but will hurt many businesses and pharmacists in the process.

**Mr Jim Wilson (Simcoe West):** You've given a very thorough presentation of the facts from a retail pharmacy perspective. It's unfortunate that the government doesn't appear to be budging on this although I think we had some pretty compelling evidence yesterday from Zellers in describing the non-traditional pharmacy and in explaining the retail business to a government that doesn't understand the retail business, in my humble opinion.

**1520**

I notice on the front page of today's Citizen, as we see the government about to cave in on the cigarette tax, that in this area of the province, when 5% of your sales is tobacco, people must understand what the effect is if you remove that 5% on your companion sales. If there's an area of the province, surely to goodness, that understands it, it's this. It's on the front page of the paper. It's been on the front page of this paper several times in the last few weeks. Here's a fellow talking about his cigarettes sales being down, because obviously people are buying their cigarettes in Quebec. His companion sales are down on things like milk and bread and other things by 25%. It would be the same effect in pharmacy.

I really don't have a question other than to thank you, and to let everyone know that all three parties agree on about 98% of this bill, and we just are bogged down over this. I think you're right to point out that the Environics poll shows that two thirds of people see pharmacies as retailers. I agree that the ban itself will have no effect on reducing consumption or discouraging young people from starting to smoke. Thank you.

**Mr Abdalla:** Can I just close with one phrase that has guided me in my career? It's from a wise business person. It's simply, are we doing the right thing, and are we doing the thing right? I think we're doing the right thing, but we're not doing it right.

**Mr McGuinty:** Mr Abdalla, thank you very much for coming in and making a presentation before us here. Your business is located within my riding, and when I think of a pharmacy, I have to confess, I always think of yours, because that's where my wife and I shop.

You've made a very important point here, and that is, it's not our perception of a drugstore that is important here, or our understanding of what it is. I think it's the ordinary person on the street's understanding that's important and that the poll that was released I guess yesterday or the day before confirms what I'd always thought of a drugstore. When I go to your store, I go there—my wife goes there more often than I do—but we get shampoo, toothpaste, razor blades, nail polish remover, chocolate bars, maybe chips and diapers. But from time to time we get a prescription filled. That's how I think of your place, and that's how I think a great number of consumers in this province think, and that was confirmed yesterday by the poll. Thank you.

**Mrs Haslam:** I'll probably be the only one with a question.

**The Vice-Chair:** That's noted.

**Mrs Haslam:** I think the problem here is that we are



a committee dealing with health issues, and when we have Shoppers Drug Mart people come in, we see your company, your head office company, your parent company, being a tobacco manufacturer, Imasco, which brings up a conflict of interest. We see the college of pharmacy come in, we see the faculty of pharmacy come in and say, "A pharmacist should never knowingly condone the dispensing, promoting, or distributing of drugs which lack therapeutic value for the patient." We see a conflict of interest, because a lot of the Shoppers Drug Mart people and the Pharma Plus people come in and talk bottom-line profits. So we, as a committee, have to look at, is this about health, or is this about the income of one chain or a couple of chains in the drug mart area?

In your presentation you talked about, "We must do everything we can to ensure that not even one more young person starts smoking." I agree with that, because in Brantford, 28% of the young people polled bought their cigarettes at a drugstore. In Thunder Bay we had a 12-year-old come in with eight packages of cigarettes—12, not 18, not 16, not 15; a 12-year-old. He bought them at a Shoppers Drug Mart. One of the packages he was able to get at a Shoppers Drug Mart. So I agree with you that it is important that we keep people from starting and that one young person, whether it's in Brantford or Thunder Bay, getting his cigarettes at a Shoppers Drug Mart should be important to us.

So when you talk, "It's not making a hill-of-beans difference if pharmacies do or do not sell tobacco," I'm afraid I have to disagree with you, because statistically in your Coopers and Lybrand, 13% of your tobacco sales are from drugstores, and according to OCAT, Shoppers Drug Mart is a third of that. So I think that we have to take a look at what a drug mart is. Is it a health facility, or is it retail? Everyone's coming, saying, "Well, we're both." We have to decide on this one that it can't be both. So if it's over 13,000 people dying a year, and by decreasing the access points and decreasing the numbers of smokers or the number of starters, it is important that we do that.

In your 5% sales, is that calculated on a profit level, because we know that tobacco is not a profitable product. It is when you have side sales. But as a profit level, considering the time your staff spend uncrating, crating, doing the shelving, I know that it's a cash flow because you don't pay for the products. You get them and then you sell them and then you pay for your products, and the turnover is quick. It's a good cash flow, but profit level, how profitable is it?

**Mr Abdalla:** It would represent in my business probably \$50,000 of bottom-line profit. That's two employees, very well-paid employees, I'm going to have to delete. I'm concerned about that.

**The Vice-Chair:** Thank you for your presentation and answering the questions. We really must move along.

PETER TOMALA

JIM BISHOP

**Mr Jim Bishop:** Good afternoon. Thank you for allowing us to present this submission. My name is Jim Bishop. I'm a practising pharmacist in Ontario and have been so for about 27 years. Previous to that, I practised pharmacy in England for one or two years.

**Mr Peter Tomala:** My name is Peter Tomala. I've been a pharmacist in Ontario for approximately 20 years. I work for a Pharma Plus store but I'm not here to represent them. I'm here as an independent pharmacist. I'm here because I'm basically concerned more about health care. Having two children over the age of 20, I've seen a lot of things. We're here I guess today to address Bill 119, which to us has two main facets, one being financial and one being a health care issue.

As pharmacists, we're health care professionals, but we work in a retail environment—that's blatantly obvious to anyone who's ever been in a modern drugstore—and that creates some conflicts. It always has and it always will: conflict between the professional side and the retail side. It's kind of like the conflict between a Minister of Health and a Finance minister when it comes to questions such as tobacco revenues.

I was shocked when I saw the front page of the paper today, I'll tell you. I hope Ruth Grier is holding up; very detrimental to health care.

**Mrs Cunningham:** You should see Karen Haslam.

**Mr Tomala:** I'm sorry, I've got my glasses off.

**Mr Haslam:** Mr Chair, I'm having much difficulty hearing him. I'm sorry, I didn't hear what he said.

**Mrs Cunningham:** It was a compliment; you missed it.

**Mrs Haslam:** I missed it? Boy. Put it in writing, send it over; thanks.

**Mr Tomala:** Where was I? Yes, we have a conflict because we're health care and retail.

One thing that concerns me, according to the Health Disciplines Act of Ontario, in clause 117(1)(g), a pharmacy is defined as follows: a pharmacy "means a premises in or in part of which prescriptions are compounded and dispensed for the public or drugs are sold by retail." 1530

One of the functions of the Ontario College of Pharmacists is to accredit pharmacies, which, according to the law, are the areas where prescriptions are compounded and dispensed. That's the definition of a pharmacy. Is the legislation in Bill 119 proposing to redefine the definition of what a pharmacy is from the Health Disciplines Act? If it is, I'd sure like to know that beforehand, because I see nothing there.

Further, taking that definition which is already standing on the books, is it your intention to allow interference with a large department store and grocery store outlet such as Loblaws, Zellers or soon-to-be Wal-Mart? Because if that's your intention, to redefine pharmacy, you are not talking about possible job losses or hour losses; you're talking about complete cutoff of pharmacies right there. No ifs, no ands, no buts, no jobs. "Buts" and "jobs" went together well, I thought.

**Interjection:** Tsk, tsk, tsk.

**Mr Tomala:** Bad pun, but I'm known for that. It's also interesting to note that the Ontario College of Pharmacists, which is a legislative and regulatory body, not a voice of pharmacy, but an arm of the government, can and does enforce distance requirements for the sale of over-the-counter medications that must be sold by a pharmacist.

In Ontario I do not believe there is a definite distance spelled out. It's done more on a discretionary basis

depending on each individual pharmacy and what's considered to be appropriate, which means basically that if I'm selling my Tylenol and my Neo Citran, it can't be 150 feet away. It has to be close to that dispensary so that I'm able to control and counsel in the sale of that product. That's part of the definition that the college uses, which would seem also to infer that a pharmacy is a set part of a retail store. Remember the phrase when we're talking about premises or part of a premises.

In other provinces, particularly BC, there is an actual set distance where drugs must be kept. Also, in Quebec a number of years ago regulations were set up that the pharmacy part could be divided off with a closure—wrought-iron railings etc. Indeed, the part that dealt with prescriptions and over-the-counter medications could be closed off, leaving the front of the store open when the dispensing area and pharmacist were not there. How is this legislation affecting us there?

If you do amend the legislation to accommodate Wal-Mart, Zellers, Loblaw's—and there are some in Ottawa that have pharmacies in them—where do you draw the line between what's pharmacy: 1,000, 5,000, 10,000, 150,000 square feet? I don't see anything in Bill 119. I hope you will all think about that.

From the situation where I say there'll be an automatic job loss from pharmacy closure in these types of outlets unless the law is changed, I also see the possibility of job losses in what we term a regular retail pharmacy. I'll speak personally on two situations for Jim and myself.

I know there's a Coopers and Lybrand study out that refers to job loss potential and revenue potentials. I won't deal with those that much. I've seen them. The figures look realistic and reasonable to me. I assume they've done their homework.

In our situation, last year in Jim's store, which is not a high-volume tobacco store, he showed a 30% decrease in his tobacco sales. Fortunately, because he's a low-volume tobacco store, he was able to maintain his sales in other areas of the store and didn't have any job losses. However, if he hadn't lost his 30% in tobacco, he's quite sure that he indeed would've hired additional staff.

In my personal case in my store, last year our tobacco sales were down 25%. It resulted in a net loss of \$110,000. Again, we're not a high-volume tobacco store, but because of that loss, and strictly that loss, because the other areas of sales were up marginally, as expected, from year to year, because of the direct loss on the tobacco, our manpower was cut 1,000 hours. That's no ifs, no ands, no buts. That happened.

If I were to lose tomorrow my total tobacco sales I had last year, it would result in the loss of approximately 3,000 hours in labour. Both Jim and I feel lucky in a sense because we feel the loss in cigarette revenue, tobacco revenue, was due strictly to the smuggling phenomenon in Ontario and those sales did not go to other competing retailers. It's my feeling and Jim's feeling that had it gone to other retailers we compete with, those losses would have been considerably more.

That's a brief outline of the financial area we are concerned about. I would say, though, that our main concern and our main thrust in being here is to address the health care issues involved with tobacco use.

**Mr Bishop:** One of the things, having listened to some of your submissions in the past few weeks, that really perturbed me was an attitude of both the committee and people submitting to you that when walking into a pharmacy, drugstore, whatever, one expects to purchase products which are healthy and safe. The reason I'm perturbed is because in actual fact this is a total contradiction of what actually a drugstore's all about.

We as pharmacists are there to control, monitor, advise and disseminate information on drugs and poisons. It is this aspect that creates the retail problem of our health care professional attitudes. This is one of the areas for which we are trained and this is one of the areas where we fulfil our commitment to our community. We have to make sure that these drugs and these poisons are used in a proper way to make them safe and healthy; in themselves, they're not.

In our situation, because we have been sort of separated from the accepted health care professionals like doctors and nurses because of our retail environment, we have normally taken no moral stand on either side of this poison and drug sale issue. We have offered our advice in good faith so that the consumer can make his or her choice. Tobacco use is in conflict with our commitment to health care. Of that there is no doubt. Similar situations have existed in pharmacy and will continue to exist in pharmacy; as an example, the selling of syringes to drug abusers. Do we sell them and therefore encourage drug abuse or do we sell them to prevent hepatitis and AIDS? Some would have us, because we sell condoms, promoting sex in teenagers. Others would have us, because we do that—we promote safe sex. These are all ethical conflicts, all created in a retail environment.

The college, as such, does not in any way usually help us in these situations; it is left to the pharmacists to decide on their own principles and ethics what they're going to do in a given situation. But because tobacco has—I believe it was said by Karen Haslam—no redeeming features, no legitimate use or no—perhaps I've forgotten your wording—we take tobacco as an exception and we do consider this of prime health care concern. We also believe that we should be working on a control program to eradicate tobacco use in Ontario. We submit, though, that tobacco is not just a commodity and should not be treated as such, as this committee does and as the majority of the population does.

**1540**

Let's consider one case. The recommended daily dosage for a nicotine patch is 21 milligrams. The recommended dose of nicotine gum is 20 milligrams. The average smoker who smokes one pack a day can go anywhere he likes and buy 35 milligrams. Accepting this and all other ingredients that are in tobacco, it appears illogical to treat tobacco as a commodity to be sold retail in any and all outlets except pharmacies.

Further to this argument, it would seem that rather than bury our heads in the sand and pass on this problem to convenience stores etc, as a health care professional along with other health care professionals, along with the Ministry of Health and indeed with the government of Ontario, we should embark on a long-term sensible approach to the eradication of tobacco use in Ontario. We



think this program should involve an increased anti-smoking campaign, advertising similar to that initiative started by the federal government. We thought it should be legislated less visibility, we feel that there should be generic packaging and many other instances brought up by people making submissions.

We also feel that from a health care standpoint the best place to disseminate this information is at the point of purchase. I make a comparison to responsible drinking and the LCBO.

A further approach would require the availability of counselling, smoking withdrawal methods, general information on dangers and information on drug interactions, pregnancy concerns etc. We do not, as professionals, believe that these objectives can be accomplished at convenience stores, bars, gas stations or grocery stores. We feel that they can only be accomplished at some controlled situation such as the LCBO.

By simply transferring tobacco sales from drugstores to others, we are not, regardless of what the statistics say, addressing the real issues. Furthermore, we are handing tobacco sales over to retail segments which have historically shown, even in the newspapers, a total disregard for the law. They are now threatening to sell contraband cigarettes, which probably is now going to be stopped by the new Ontario government initiative.

That, basically, is our position from health care professionals. We are concerned. We do not feel that putting the age up to 19, first of all, is going to make much difference. Yes, it might make a difference to one or two, but it seems to me that is not broaching the subject. That is making points, as far as I can see it. Not selling tobacco in pharmacies does the same thing. It won't make any difference to anybody. Instead of the 23% buying in drugstores, they're going to go to convenience stores, and I don't see that in itself is addressing the issue. We all want to reduce tobacco smoking in Ontario, and I hand over to Peter.

**Mr Tomala:** We feel strongly that tobacco use should cease in Ontario. We think that is the ultimate objective. We think the section that deals with banning it in drugstores is a waste of time in that regard. We feel that a long-term approach is needed, involving education primarily and a concerted effort between health care professionals and the Ministry of Health, other trained professionals and indeed the entire government of Ontario to eradicate the problem. If the government is going to interfere in the sale of a legal product, we feel it should do it in a non-discriminatory way and, further, in a way that will result in long-term objectives being reached.

I'd like to thank you all for your time and patience.

**The Vice-Chair:** Thank you for your presentations. I'm sorry there isn't time for questions.

#### OTTAWA-CARLETON COUNCIL ON SMOKING AND HEALTH

**Ms Carolyn Hill:** I'm Carolyn Hill and this is Julie Shouclie. The Ottawa-Carleton Council on Smoking and Health is a volunteer community coalition and we were founded more than 20 years ago. The council's mission is the elimination of tobacco products from Ottawa-Carleton.

The coalition is a member of the Council for a

Tobacco-Free Ontario. Our member agencies include the Canadian Cancer Society, the Heart and Stroke Foundation, The Lung Association, Addiction Research Foundation, Ottawa-Carleton regional health department, Non-Smokers for Clean Air, Ottawa Regional Cancer Centre and the heart check centre at the Heart Institute of the Ottawa Civic Hospital.

The council also has a number of interested individuals who've spent many years as volunteers working in the trenches in the war against tobacco. As your first presenter, the council's current president, I am one of those battle-fatigued warriors. I have been a volunteer for more than 20 years, primarily with the cancer society. One of the first acts indicating my commitment to this cause was to insist that a volunteer who arrived for training at an education meeting in Stratford not smoke at a coffee break that we were having in the evening. This was in 1972 when very few organizations had any policy regarding volunteer smoking. It just seemed like it was the right thing to do.

I do not shop at pharmacies that sell tobacco. I try not to purchase foods that are produced by subsidiaries of Philip Morris or RJR Nabisco and I miss my Kraft cheese. I clearly would love to shop at any grocery store that didn't sell tobacco products and I would drive some distance to find that store, if I could find one.

Tobacco use kills more than 700 people in Ottawa-Carleton each year and it is this area's leading cause of death, disease and disability.

The Ottawa-Carleton Council on Smoking and Health supports the targets for tobacco-use prevention adopted by the regional municipality of Ottawa-Carleton and works with each of our member agencies to assist in the realization of those targets. They are listed in my submission.

The coalition has been very active in the encouragement of the government to draft strong legislation, and submitted a document outlining its concerns in March 1993. The council was very instrumental in organizing a rally in the fall of 1993 outside an Ottawa hotel where the provincial cabinet was meeting. It was the purpose of this rally to urge the government to table its proposed legislation and we like to think that maybe we had a little something to do with it.

As recently as last Friday, we were visible and vocal again as we organized a rally for health: Protect our Teens. This rally was designed to allow the citizens of Ottawa-Carleton to show support for our provincial government, as it had resisted following the federal government action with a provincial tax rollback.

The local council applauds and strongly supports the government's move for introducing the Tobacco Control Act. It is, I believe, the most significant piece of tobacco control legislation introduced in the history of the province. The official opposition and the Progressive Conservative Party are to be congratulated for their support of this proposed legislation and we urge you all to pass it quickly, because the health of young people is clearly a non-partisan issue.

I will speak only to some of the highlights in my

submission to allow us some time for questions.

With regard to the prohibition of the sale of tobacco in designated locations, I believe cigarettes should not be sold in pharmacies and we applaud the government for responding to the request of the Ontario College of Pharmacists who have been asking for this provision for over two years.

The council was one of a number of agencies that sponsored an advertisement in the local TV Guide in November 1992 identifying pharmacies in the area that did not sell tobacco products. The number of pharmacies has grown substantially since that time.

A major benefit of the termination of tobacco sales in pharmacies is the elimination of a conflicting message about the risks of tobacco products. That conflicting message we're sending to people of all ages, but especially to our young.

1550

We would suggest that, in addition, tobacco sales be eliminated from educational facilities, child care facilities, government workplaces, public transportation kiosks and convenience and corner stores. Clearly, what our coalition would recommend is that the sale of tobacco be limited to a network of licensed tobacco control outlets.

This action would eliminate the practice of food delivery operations such as pizza sales outlets, many of whom have young drivers, delivering cigarettes to young people at home.

A licensing system financed by licence fees would control who sells cigarettes and to whom the cigarettes are sold. It would provide an effective enforcement system without burdening the police or the courts.

Packaging controls and health warnings will facilitate eliminating the tobacco industry's remaining advertising vehicle: the pack itself. Ontario is in a position to take an unprecedented lead on this issue. A recent study released by the Canadian Cancer Society regarding plain packs makes it clear that teenagers associate a plain pack with wimps and losers. Plain packs make the product less interesting and have an even greater influence on young kids who are contemplating smoking. This is a critical group that we should be trying to affect. Plain packs also make the health warnings much more visible.

Plain packaging can do one more important thing: It can break the link to other advertising and promotions. We know that by connecting advertising for events with the colours and designs used on tobacco packages, the industry effectively promotes its product.

During national Non-Smoking Week, the council visited high schools in the area and we had a question-and-answer board. There was a question that asked, "Is tobacco advertising banned in Canada?" and they all answered the question, "No." They said, "We see signs of what we consider to be advertising every day." Clearly, the loophole in the current act is being used to the manufacturers' advantage.

Since up to a quarter of the population has existing heart, lung or allergic conditions that can be aggravated by tobacco smoke, we strongly recommend that a long list of additional areas be added as prescribed places

where no person shall smoke tobacco. That list is in my submission.

Finally, Bill 119 makes no attempt to improve the government's largely ineffective workplace smoking legislation. This is a glaring deficiency and one that needs to be addressed. The current legislation gives virtually no protection to an employee working for an employer who wishes to allow smoking in his workplace. If we are to reach the provincial target of smoke-free workplaces by 1995, we have to have a tougher smoking-in-the-workplace act. As you know, it currently takes up to about two years for municipalities to get enabling legislation. This is unacceptable. It makes it virtually impossible for us to reach our target.

**Ms Julie Shouldice:** My name is Julie. I'm an OAC student in Ottawa. I want to start out by saying that no matter how many warnings are issued or health classes are taken, high school students repeatedly ignore the dangers they know exist and begin smoking. Ignorance is no longer the issue, as students know the effect their habit has not only on their own health but also on the secondhand smoke they're inflicting on others, yet they continue to light up at an alarming rate. Rather than the number of teenage smokers decreasing, which is what we'd hoped for by this increased education, the number of teenage smokers is actually increasing.

At the high school I attend, almost all of the students have tried smoking at some point, which in itself isn't a bad thing. However, a large proportion of them continue their habit past the first cigarette and smoke for almost their entire secondary school careers. Whether their habit involves a few cigarettes a week or three packs a day, it's important that we begin steps to reduce the number of smokers, especially among our youth population.

There are two problems, as I see it, associated with smoking at the high school level. These are the problems of accessibility and acceptability. The government of Ontario has the opportunity to control the accessibility of cigarettes, and hopefully their acceptability will drop proportionately to their supply.

The first issue I wish to address in the new legislation is the change of minimum age of purchase of cigarettes to 19 years. This is important because it makes buying cigarettes illegal for almost all students at the high school level. This change goes hand in hand with the decision to prohibit tobacco sales in designated areas such as pharmacies or hospitals. The more access students have to cigarettes, the more likely they are to smoke. It's important that there are as few places as possible for students to obtain tobacco products and few of their peers able to buy for them.

Along the same lines, the increased fine for shop owners who sell tobacco products to minors has the potential to decrease the number of underage smokers. There are students as young as 13 or 14 smoking at my school. We would like to believe that these people are forced to ask older siblings or friends to buy their tobacco for them, but the reality is that most of these underage students are able to buy tobacco in almost any store they frequent. By limiting the accessibility of cigarettes and increasing the effort required to obtain



them, there will be a reduction in the number of students smoking, because we all know that students are somewhat lazy.

It is equally important to enforce the prohibition of smoking in public places, particularly in schools. Although currently students must be 18 years old to purchase tobacco, when you drive by any high school almost anywhere in the province you can see students of all ages outside having a smoke between classes. The government must make a move to prohibit smoking not only in the school building but also on school grounds. The effect of constantly seeing students smoking every time one enters or leaves the building does two things: first, it promotes smoking as a socially acceptable pastime; second, it encourages younger students to pick up the same habit. It is ironic that, when asked, most students admit they didn't enjoy smoking when they first began. They persisted, however, because it was the cool thing to do and because most of their friends were smoking. When students are inundated at school by peers who smoke, it's only natural that they'll follow suit and begin as well.

I feel the government should also take a further step and ban advertising and promotion, either direct or indirect, of tobacco products. When students hear their favourite sports or entertainment events are being sponsored by the tobacco industry, it once again raises the social acceptability of smoking. It's important that the government send a clear message that smoking is a health hazard and not an essential component of the events they attend.

Students like to be rebellious, which is perhaps one of the main reasons the number of teenage smokers is increasing. However, rebellion is at its optimum state if the source is destructive and accessible. Smoking, without a doubt, is destructive both to the health of the students and to their environment, but it can easily become less accessible. It is important to remember that very few people begin smoking after their teenage years. Most of the years that you get hooked on cigarettes are while you are in high school. If we can limit accessibility, there should be an overall decrease in the number of smokers, which would then lead to a decrease in the social accessibility of smoking.

**The Vice-Chair:** We only have time for one question. Ms Haslam.

**Mrs Haslam:** I appreciate your letting me ask the question, because I come from Stratford.

**The Vice-Chair:** Your husband was up first.

**Mrs Haslam:** That's because the minute she mentioned Stratford my hand went up. We're fine and we're doing quite well in the anti-tobacco area. I'm doing my cable show this week on the new tobacco legislation and I will certainly mention that to the lady I'm meeting with.

I wondered about a couple of things in the presentation. You're talking about the pizza sales outlets delivering cigarettes to young people. Are you aware of how prevalent that is? This is fairly new to me.

**Ms Hill:** It's fairly prevalent. I could probably produce six or seven ads that get delivered in your

mailbox. They have what you can order in terms of the pizza, but it also says "Cigarettes delivered." It's usually not the regular price; it's usually a little bit of a reduced price. It's just an incentive for kids to call up, order the pizza and say, "And bring me a pack of cigarettes." It isn't just in this area; it's in other parts of the province.

**Mrs Haslam:** It's a point I don't think we've really dwelt on because we haven't heard too much about it and I appreciate you raising that. I also appreciate you raising, on page 8, the fact that environmental tobacco smoke contains over 4,000 chemicals. That's just the environmental tobacco smoke. We received in our package today 11 pages listing the elements in a cigarette and one of them, according to what I was told, included Varsol and the toilet bowl cleaner formulas. I think that's something the young people should be made aware of more.

1600

**Ms Hill:** We're using a current poster of the cancer society that shows the large cigarette and lists all of these chemicals and says: "This one is in battery fluid. This one is in Varsol." They can't believe that the same chemicals are there.

**Mrs Haslam:** I have another point and then I'd like to talk to the young person. You mentioned chewing tobacco. We've just recently seen something on chewing tobacco. But you said you want a prohibition on the manufacture or sale of any new tobacco products.

**Ms Hill:** If there were to be an additional kind of product, such as—oh, I don't know. I'd hate to think what they could dream up, but we know that if we start eliminating things, these guys are smart; they'll dream up some new product. If they should dream up a new product that you could chew on or whatever, at that time it should not be accepted as a product to be sold. I'm just afraid they'll find another loophole.

**Mrs Haslam:** We haven't heard that often enough and I wanted to just kind of get an idea about that.

For Julie, I was interested to see that you were talking about access points, which is what we're looking at. Maybe I'd ask the parliamentary assistant to clarify the school grounds for you because I know you mentioned smoking on the school grounds. I think it's important that the parliamentary assistant give you a clarification of that.

But you talked about trying smoking at some point and never getting past the first cigarette. I think that's where we are really concerned, is that nicotine is as addictive as heroin and cocaine, and I know from facts that I have that nicotine from an inhaled cigarette reaches the brain in seven seconds. Would those kinds of messages to young people help?

**Ms Shouldice:** I think the reality is that most young people have been inundated with facts. They are required to take a gym class in which the information about tobacco is already given. We held an assembly where, once again, we told students what the tobacco issues were, but the reality is most of them frankly don't care. Whether they go to the gym class and they listen, I mean, they already know what the problems are. What we have to do is start limiting, as I said, the accessibility and the acceptability or they're not going to stop. Unfortunately,

most students do know how terrible it is for them, but they continue to do it anyway.

**The Vice-Chair:** Thank you. Does the parliamentary assistant wish to comment briefly?

**Mr O'Connor:** Yes. Just on the point on the school property that you've got in here, we've used the definition of school from the Education Act, which actually includes the school property. The other thing, two down, is that you've mentioned adult education facilities. My thought is here that I thought we probably covered that off because most often adult education facilities are in schools and they'll use the schools in the evening. But if you can give me something that might say that we're not really covering it off and want to add to that, I would certainly be glad to hear from you on that.

**Ms Hill:** Okay. We'll provide it.

**The Vice-Chair:** Thank you very much for your presentation. It was very informative.

JAGDISH DATTANI

**Mr Jagdish Dattani:** My name is Jagdish Dattani. I own an independent drugstore in Bells Corners in Nepean. I thank you for granting me this opportunity.

In my store, there are about 12 people: six full-time and six part-time. I want to make it very clear at the outset that I don't support selling cigarettes in a drugstore. But I feel this shouldn't be mandatory; it should be voluntary. We cannot legislate everything.

Next to my store there's a little corner store, and if you ban cigarettes from the pharmacy, they'll just walk one door more and get it from the convenience store. It feels like you are robbing Peter and giving the business to Paul. I feel there's slight discrimination there.

The other point is that we do sell cigarettes in our store. We don't make much money out of tobacco sales, but the peripheral sales, the companion sales, are a great help, and if we stopped selling that, I think we would lose substantial sales in the peripheral sales, like candy and Kleenex and stuff like that.

Also, when the province was giving us fees for prescriptions under drug benefit, they reduced our fees in the back and told us to make it up in the front shop, but now we are finding that if we take the tobacco from the front shop and if our peripheral sales drop, our profits again will go down in the front shop too. For a small pharmacy like ours, it will make a lot of difference for struggling in these hard times.

The other thing that bothers me is that big department stores and megastores probably will be selling tobacco. What steps are being taken that if they are a pharmacy, they don't sell tobacco? Will this somehow circumvent the legislation? We don't quite understand how the government is going to sort that problem out.

I feel strongly that giving up tobacco is more a matter of education rather than legislation. Government should spend more money on advertising about kids and other people not smoking. It's just like bacon and eggs. We know they are not good for us if we eat them every day, but we don't legislate and say that you can't eat bacon and eggs or that the store can't sell bacon and eggs. We teach people what's right for them and let them make the

right decision. So I'm more for public education and I think tobacco sales in the pharmacies should be stopped, but it should not be legislated; it should be voluntary. Thank you, sir.

**Mr Jim Wilson:** Yes, just to really thank you, sir, for your comments. I think you're into a bit of an uphill battle, as you can imagine, because the deal that was made as this legislation was being put together, at least the deal between some of the health groups and the government, included this ban on the sale of tobacco products in pharmacies. Unfortunately for these hearings, the Minister of Health has never been here to hear your side of the story. She obviously has heard the other side of the story, but she's not been here to hear any of the retail arguments. I just wanted to make that comment.

I was sort of hoping actually that I would have had a chance to ask the young person Julie, the presenter before you, about this because I think that the health care individuals very much feel that if they ban it in pharmacies now, that's a good first step, and that's what they tell us. It's pretty hard to argue against that and it's difficult, I think, to argue against the fact that the other selling point, from the government's point of view, is that pharmacists are health care professionals and they shouldn't be selling tobacco. You would agree with that probably, too.

But you mention you're right next door. In fact, there'll be 120,000 retail stores outside of pharmacies—

**Mr Dattani:** Especially smaller stores like mine. We are not a Shoppers Drug Mart or a Pharma Plus, like big stores. We are a small store.

**Mr Jim Wilson:** You're an IDA store.

**Mr Dattani:** Guardian, yes.

**Mr Jim Wilson:** So you're not owned by Imasco?

**Mr Dattani:** No.

**Mr Jim Wilson:** I just want to make that clear because that comes up.

**Mr Dattani:** No, I own it myself.

**The Vice-Chair:** Thank you very much for your presentation. We're pleased to have you.

KEITH PRATT

**Mr Keith Pratt:** Thank you for allowing me to speak to the committee. Just to pick up on the last presenter, my name's Keith Pratt. I'm a pharmacist and co-owner of three independent pharmacies in Smiths Falls, about an hour from here. Smiths Falls has a population of about 9,000. As far as I know, other than my partner, I'm not accountable to Imasco or anybody else. I'm independent.

There are three stores in our small company, three small pharmacies. Our major competition is a major pharmacy chain in our town, as well as several non-pharmacy retailers. We voluntarily stopped selling tobacco three years ago. Coincidentally, we played, I suppose, a political game because we stopped selling in the month of April. We did it during the daffodil campaign and had the cancer society come in. We made some publicity out of it, no doubt about it. Why not? We thought it was good and they thought it was a good idea, too.



1610

Sure, initially our gross sales dropped, I don't deny that, because we were a medium-selling tobacco retailer, if you will. But I want to make the point that we survived. We adapted, we recovered, we didn't lay off staff, we didn't reduce staff, we didn't lose our customer base. I will admit that we laboured long and hard before we made the decision because we were afraid, not only that we were going to lose sales in tobacco, but that we were going to lose companion sales. What we found was that largely our fears were unfounded. The people who were buying tobacco, that's all they were buying. They weren't really shopping otherwise. We didn't lose our customer base. I know that's the fear of a lot of pharmacies, that not only are they going to lose their sales of tobacco; they're going to lose customer base because those people will go elsewhere for other things. In our experience, that didn't happen.

I contend that retailers, pharmacies specifically, but all retailers have to continue to monitor and to continue to have to be adaptive and flexible to the community around them, to society in general, and to prepare to alter product mix, not just tobacco. I would suspect that all pharmacists have to monitor, or should monitor, their product mix all the time. Tobacco, I think, is just one product out of a whole scale of products that should be continually monitored all the time. No pharmacy owner, in my view, should count on one aspect of his or her business to make or break that business.

What I'm hearing is that pharmacists are telling you, the committee, that if this bill passes, this act is going to break businesses. I contend that's a bit alarmist, from my own personal experience, and those people should be—well, I suppose what they should be doing is adapting now. They should have adapted a long time ago. But everybody has to adapt to the changing environment. I've thrown out things in my store just because they haven't sold. I threw out tobacco because I thought it was the right thing to do at the time.

We haven't sold tobacco products for three years now. Perhaps I missed something, but when we were selling tobacco our margin was no more than 10% or 15%. We stopped the sale of cigarettes. Once we did that, our overall margin went up. Our gross sales went down for a period of time, but the margin went up. In pharmacy, 10% or 15% on an item is low compared to the margins of 25% or 30%-plus that other products bring in.

The proposed reduction in the province's tax on tobacco, which it is speculated that the Minister of Finance is contemplating even now, in my contention is even going to reduce the cash flow that pharmacists are talking about. Cash flow is important, I realize that. But if the actual price to the consumer drops, that means that the actual cash brought in by the pharmacy will drop too; cash flow is gone. Sure, it's not profit to the pharmacy, but still, that will be reduced cash flow, regardless of where it eventually goes.

From our experience, the customers didn't boycott our stores because we didn't sell tobacco. I think if retailers are willing to adapt to a changing market and social conditions, a rapid recovery from the loss of tobacco is

easily obtainable. If the loss of tobacco sales actually results in store closures, as has been suggested to this committee, perhaps one wonders if those stores really could call themselves drugstores or tobacco shops.

I don't think it's fair or accurate to blame any impending store closure or staff layoffs on the pharmacy tobacco ban. A quick example: We have a delivery service in our town. It's a free delivery service for everyone, whether they live two doors away from us or five blocks away. My partner and I now are considering having a copay, user-pay, something fee. If the press picks up on this, I'm dead. It's not because we have been suffering because of tobacco sales. It is because our overall sales are decreasing. The drug benefit plan, as many of you know, has chopped a lot of drugs off the plan. There have been reduced drug benefit fees. Our front-shop sales, if not reduced, certainly have been greatly curtailed as a result of competition—market forces, if you will.

We're not contemplating these service changes because we aren't selling tobacco. We're contemplating them because of overall economic pressures. Maybe I can contend that other people may be doing the same thing. They can blame a tobacco ban but I contend that may not be the true and full reason.

I'll switch into another point. The Ontario College of Pharmacists' role, as I understand it as a pharmacist, is there to protect the public on issues relating to pharmacy. I wonder, is the public being protected by continuing to allow pharmacists to sell—the old word—cancer sticks? I certainly don't expect the College of Pharmacists to necessarily act on my behalf. They're there to act on the public's behalf, and that's where this whole issue kind of started.

Many opponents of the bill say they endorse the overall intention of the legislation to stop juveniles from smoking. What about the rest of the population? Could it not be interpreted by the public at large that pharmacists against the bill are sending a message that says, "It's okay to smoke if you're 19"?

We call ourselves health professionals. As such, we read reports and hear about it first time all the time and see tragic results that are caused by smoking. I think we should be taking the lead as pharmacists in sending the message to the public. I think that's the important thing, what the message comprehends. The public's not behind me; the public's out there. They're going to take the lead from, yes, the politicians but also what the health professionals are doing. I think it's a clear message that we can send.

Many pharmacists support the removal of tobacco from pharmacies and they also applaud the government's intention in this bill to curtail tobacco consumption. Some of those same pharmacists also are saying that they shouldn't be curtailed in selling tobacco. I see that as inconsistent. They want to be able to continue selling cigarettes so their businesses don't suffer, but they also want the public to stop smoking.

Sooner or later the public or society is going to continually make it uncomfortable, if you will, for the public to continue smoking. So sooner or later pharmacies, whether it's legislated or whether it's voluntary,

are going to stop selling tobacco. I still contend that it's time to adapt, folks; it's time to get on the bandwagon and stop now.

Unfortunately it's true that pharmacy's very divisive on this issue. Otherwise, probably a lot of this committee work wouldn't be necessary. But it's my contention that even if the legislation didn't pass and you let nature take its course, if you will, I'm afraid, from my observation of my colleagues, that there are going to be some diehards out there who are going to be like dinosaurs. Way past the time that society says it's really wrong to smoke, those pharmacies will still be selling tobacco come hell or high water.

My last point: As I probably said before, I agree the legislation won't directly affect tobacco consumption. I also feel that we as health care professionals need to lead the fight. I think in fact this act really is a first step, as has been said before. It probably should be a first step in the eventual elimination of tobacco sales throughout the retail industry, at least curtailed to well-controlled environments.

Thank you very much for allowing me the opportunity.

**Mr Dadamo:** Mr Pratt, thank you for your presentation. I guess by now you know that there was a press release issued out of Queen's Park yesterday on behalf of the Ontario Campaign for Action on Tobacco. They say, and now I'm quoting from the press release, "'This poll finds that 55% agree with the pharmacy ban.'" It "shows that a majority of Ontarians agree with the ban on the sale of cigarettes in drugstores, which is part of the province's new tobacco control legislation—Bill 119."

But there was a line that I picked up from your presentation that says, "Why haven't pharmacists begun to prepare for this change?" I've been thinking about this for about a week now. If the trend is that 55% agree that it shouldn't be sold in one particular spot—and I think we're picking up the fact that it ain't cool to smoke any more. Someone said to me not long ago that there will be two places, probably, in the future that you can smoke, and one will be your home, and your car. If that is to be in the years to come, why haven't pharmacists begun to prepare for this change?

1620

**Mr Pratt:** I agree. Since 1989 I as a pharmacist have known that at least at the college council level of OCP this has been debated, talked about, suggested, up to where we are right now. Everybody has to adapt all the time. I think it's important.

What my problem is and why I'm here today is listening to pharmacists say, "Something's going to happen if I'm not allowed to sell tobacco." They can voice their objection to you, the committee, but I think they also need to start working on looking at both sides. What happens if it does pass? What's going to happen tomorrow? They have to wake up and face the real world and they have to adapt, but I think they should have been adapting five years ago, not tomorrow or not when—

**Mr Dadamo:** I said to a pharmacist in Toronto this morning that you sell medicine on this side, you sell cigarettes on that side, and I think you get into the

business, you become a pharmacist, because you study hard and you want to help people to get better. Doctors in their offices don't tell you that you should smoke, and they're trying to making you well, so I would assume that you guys think along the same lines.

**Mr Pratt:** It's a real tough one for a health professional, for anyone, but it's a really tough one because no pharmacist can sit here and tell you there's nothing wrong with cigarettes. Yes, there's nothing wrong with cigarettes as long as they're still in the pack, but as soon as somebody starts there's no benefit out of them. So how can I as a health care professional justify selling them? Pharmacists even try to hide them. It's been mentioned this afternoon that, "We keep them hidden." What kind of message is that to you if I'm telling you that I sell tobacco but I keep it hidden? I have a hard time saying that I sell something when I keep it hidden.

**The Vice-Chair:** Thank you for your presentation.

REBECCA LIFF

**Mrs Rebecca Liff:** Good afternoon. I've brought a kiddie pack with one cigarette that somebody sent me. It says, "No smoking, good to your life, for your health," and you press and it actually says, "No smoking."

I welcome this opportunity to speak to the standing committee on Bill 119. A to P are attached to support my comments and so are misleading pamphlets on or omitting tobacco by certain pharmacists.

There should be minor adjustments to close any loopholes and this bill should be passed as quickly as possible. There are some weird comments recorded for December 9, 1993, Legislative Assembly of Ontario, after the revealing, excellent speeches by Mr Larry O'Connor, MPP, and Mrs Karen Haslam, MPP.

This fall I drove past a group of boys and girls walking on Ralston, which leads to Randall, where Alta Vista public school is located. Cigarettes were passed by one student to two others and all three lit their cigarettes—three young teens, well dressed, no more than 13 or 14 years of age. This was the beginning of the lunch break and it means that one of these kids had a pack of cigarettes on school grounds. Is this kid a dealer in contraband cigarettes who's trying to hook someone else's children on nicotine? Where is the core curriculum on smoking for Ontario elementary schools? What are the provincial penalties for underage possession of tobacco products and underage peddling of tobacco?

I recall White Cross pharmacy on Elgin and Somerset having an open, white pack of introductory free samples of cigarettes next to the cash. The cashier left the cash to help a customer and any child from Elgin Street public school could have had free cigarettes easily. I can assure you I will never fill another prescription at that joint. The white pack of this new brand did not go over well and I'm relieved this brand died and did not make the marketplace.

I watch my prices at any store in which I shop. When my husband took me to the Price Club I found very little in the way of bargains, as many items were priced comparably with Loblaws etc. To stock up on cheaper bulk items is stupid when you do not use these items. A



store with some loss-leaders and promotional items does not guarantee lower prices on all items.

Do your own price watch, as on page A that I've done for you. You may be charged more for essentials so that pharmacies can sell tobacco at lower prices. Yes, pharmacies have specials on two-litre bottles of soft drinks. I cannot carry heavy bottles. I buy one or two from the supermarket, as soft drinks have a very short shelf life. I buy all my sanitary pads when needed at Loblaws for at least \$1 less per pack than at a pharmacy where tobacco products are sold. I have also purchased similar chocolate treats I used to buy at Shoppers Death Mart in packages to give out at Hallowe'en from Sears at lower prices. This past October, Loblaws had the same bars for the same low price I paid at Sears. I no longer buy envelopes, stationery or pens at Shoppers as their prices are much too high, and it really bothers me when I purchase something there, even if it is not a prescription. The shampoo we use is usually more expensive at tobacco-dealing drugstores; so are the prices of the Obus back rest and Obus support roll.

For a period of over 10 years I purchased most of our family prescriptions at Shoppers on Bank and Walkley, but have never done all my shopping there. I've never bought dresses, slacks, milk, bread, chickens, eggs, vegetables etc there and I don't understand how anyone who will purchase tobacco products at a pharmacy will purchase everything else there, as is implied by some tobacco-pushing pharmacists.

The pharmacy that opened in the Blue Heron mall over a year ago was competition for the long-established smoke shop across the street at Bank and Evans. Prices in that pharmacy were high, there was almost no stock variety and soon this tobacco pusher became part of the Guardian Drugs chain, specializing in tobacco sales. That store location is now empty.

My doctor, because of misleading information from Shoppers Drug Mart, sent me to a health devices supply store at Fairlawn Plaza on Carling to have a prescription for wrist splints filled immediately. This is what I'm talking about, for my wrists. What she didn't know was that she sent me to a Shoppers Drug Mart where a nurse tried to fit a mismatched pair of splints on my wrists because a matched pair in my size was not available. Because I had problems with one splint I returned it and replaced it with another splint from Shoppers at St Laurent Shopping Centre, where I was charged tax on that prescription. Of course, when I needed a splint replaced recently I went back to this particular tobacco dealer to fill my prescription and demand my tax refund for the illegal charge.

Because of sidestream smoke, nicotine abuses everyone breathing the air we all share. Caffeine and nicotine are more widely abused in Canada than alcohol, contrary to the claim and special pamphlets distributed by Shoppers Drug Mart to whitewash the nicotine problem. Here's the pamphlet I'm particularly angry about, and this one I obtained at Shoppers at Bank and Walkley years back.

The Shoppers chain will not acknowledge caffeine or nicotine addiction or sidestream smoke containing nicotine and other goodies, probably because they sell

chocolates, colas, tea and coffee products as well as tobacco, and that means these pharmacists do us all a great disservice on the number one deadly, poisonous drug, nicotine, that is the plague in our present society. According to their pamphlets, air pollution affects allergies, yet no mention is made either of tobacco smoke that can trigger a deadly attack in some people or the Imasco connection. I'm referring to these pamphlets and the thing on poison; it doesn't mention nicotine as a poison equivalent to cyanide.

Vending machines for the sale of tobacco should be banned. Underage smokers do rely on vending machines as a source of cigarettes. Nicotiana Tabacum describes tobacco as "a gift from the devil" who "disappeared in a grey cloud, leaving behind a nasty, sulphurous smell." It is also a stimulant. Why not regulate to put saltpetre for flavouring in tobacco to deter children, especially teenagers, from smoking?

I said to the Ottawa Board of Education trustees in a presentation that exposure to tobacco smoke on OB property helped to sabotage, at McArthur High School, the efforts of special counsellors and their students who were on a program requested by parents of teenage smokers to help the addicted students to quit smoking. Why not visit McArthur High School in committee tomorrow at lunchtime to see how the smoking policy is being abused? Why not change the name McArthur High School to Designated Ashtray?

The trustees voted to delay the issue of smoking on Ottawa Board of Education property till May 1994, dragging smoking problems for another year. Trustees' excuses were: "There are rooms at the civic hospital where people smoke," and "City hall employees smoke in front of the city hall outside the building." This issue first came up 20 years ago at the Ottawa board's Alta Vista public school. We need Bill 119 immediately, and as you can see in the enclosed letter from Famous Players, direct government intervention is the only way to resolve the smoking problem.

**1630**

OBE trustees have accused me of making inflammatory remarks, wasting paper, and one trustee even tried to restrict me from speaking at the upcoming open budget meetings. It is not only the Ontario Health ministry that is a mess; the Ontario education system is quite the costly mess. The province won't legislate to amalgamate the Ottawa board with the Carleton board, or disband school boards completely in this province, or develop core curriculums for the province, or set up a special central teachers' registry. I doubt if ratepayers will tolerate another imaginary consortium for another 20 years.

There is unfair taxation of the 70% of ratepayers who have no children in the schools. Not enough is being done to prevent our youngsters from starting to smoke and to have smokers pay for what their smoking will bring in health costs in 20 to 30 years from now. Smoking should be banned on all school property and a special \$1 pollution fee should be placed on each cigarette at the manufacturing plant.

Just look at the pamphlets put out by the tobacco-industry-associated drugstore chains, which never mention

nicotine as a drug or tobacco smoke as a part of air pollution. These pharmacists are lying by omission. I've suffered eye infections, nausea etc and have even been smoked out of a job here in Ottawa. Pharmacists should be restricted to either a licence to sell tobacco or a licence to dispense other drugs to help people in a single premises. In other words, if a pharmacist wants to sell tobacco, he should get a licence from the city or whatever. Even if the store's five feet away in a separate store, it doesn't bother me one bit, but not where he's selling drugs.

Has the kidney foundation made any presentations to your committee to promote Bill 119? Paul Paré of Imasco was campaign chairman for the kidney foundation's campaign to raise funds from Canada's top 500 corporations, and the kidney foundation gloated that Mr Paré had received the Order of Canada for all his good work in hospitals.

All the tobacco farmers and vending machine operators etc can be retrained immediately as hospital orderlies etc to fill all the jobs in hospitals that are mushrooming thanks to Mr Tobacco and his helpers, the nicotine-pushing pharmacists, the contraband tobacco pushers and now the lowering of taxes on tobacco products.

Note: Victor M. Drury, executive director of the kidney foundation, defended Paul Paré's appointment. Drury once worked with Paré as Imasco's vice-president for public affairs before he joined the kidney foundation. In 1985, more than 900 Canadians died of cancer of the kidney, one third of which were caused directly by smoking.

Paul Martin, the federal Finance minister, has some connection with Imasco. He has a conflict of interest with tobacco taxes, as he is our federal Finance minister. He should resign from cabinet. Why did he not lower or eliminate the GST?

I've enclosed samples of pizza-joint flyers. These tobacco pushers will deliver cigarettes with pizza to youngsters.

Many senior citizens who live in seniors' buildings are harmed by tobacco smoke pollution in their buildings. Vending machines and smoking should be banned in these buildings and in nursing homes, hospitals and all workplaces.

Kiddie packs of less than 20 cigarettes should be banned in Ontario as well.

Tomorrow, after your visit to Designated Ashtray, you should visit the food court at St Laurent Shopping Centre, not far from McArthur High School. You will see teenagers smoking and you can question whether or not they purchased their cigarettes from tobacco pushers in the shopping centre or whether they used other dealer-pharmacists. Because smoke rises, several months ago I had to leave the McIntosh and Watts china shop on the upper level off the food court because tobacco smoke had come into the open front of the store and got into my eyes, which were burning. I won't go back to that store and I avoid the food court section as it stinks. My clothes pick up that stench and so does my skin and hair.

I don't see how large pharmacies tend to provide better

supervision, especially when pharmacists are usually dispensing drugs and not at the cash where cigarettes are sold. Cigarettes are most visible, as pharmacies do display them all where people pay, at the main cash. That's point-of-sale advertising.

We need proper legislation, especially to ban vending machines and to restrict to non-pharmacy premises the sale of tobacco products by pharmacists and to raise the legal age of possession of tobacco smoking to 19 etc. The inaction of many previous provincial ministers, many of whom were smokers, has added to the wasted years, money and health of so many people in this big province of ours. I urge the government of Ontario not to follow the disastrous choice made last week by Mr Chrétiën. Stand fast and see that smokers pay their fair share.

We do need the legislation to reform the regional government and the school board zones. We need reform to the Election Act to be able to throw out dishonest elected officials immediately. We need reform to pay fair salaries to teachers—teachers who do not even try to enforce the smoking ban during lunch or recess etc, who work for an average of \$55,000 per school year. That works out, if they teach five hours per day for 196 days, to over \$56 per hour, exclusive of benefit costs, which would add another 20%. We need fair tax legislation etc.

I urge the provincial government and all members of the provincial Legislature to take immediate action and pass these government bills, including Bill 119, to make our province a better place for us and for the generations to come. Amen.

**Mr McGuinty:** Rebecca, it's good to see you again. Rebecca and I spent a considerable amount of time together in the non-smokers' association for Ottawa.

One of the things you made reference to at the outset of your presentation was you asked rather rhetorically whether there was any penalty for possession of tobacco. That's an idea that's been thrown around and it's met with some approval by some medical people and by some teachers as well, and I think by some parents, in terms of putting one more little obstacle in the way of young people. Interestingly enough, we make it illegal to possess alcohol if you're under the age of 19, but as you well know, the death rate associated with alcohol abuse in this province is far less than it is for cigarette smoking.

Also, the government has recently passed a law which will shortly make it illegal for young people, or everybody for that matter, not to wear a bicycle helmet. Maybe we're at 100 deaths a year in this province in terms of people who suffer fatal injuries as a result of an accident while being on a bicycle. That's 100 deaths, and we've made it illegal not to—we can fine kids. But we have 13,000 people dying in this province as a result of cigarette smoking and kids still can't be fined or can't be penalized. I just wanted to have you elaborate a bit more on that issue.

**Mrs Liff:** I tried about 15 years ago to get the Ottawa police to catch some young kids near my home who were smoking. Of course, they smoke there about 10 to 9 in the morning, which is the key accident time in the city. One day I called and there were actually three packs of kids just around the school area. The police called me



later and they said, "We were there at five to 9 and we didn't see anybody smoking." On another occasion, I was told, "We have in years past clamped down on the kids, and the parents sign a note or something and say they allowed their kids to smoke." The federal Tobacco Restraint Act allowed for a fine I think of about \$5 or something. So the Ottawa police were enforcing this for the RCMP, yet you couldn't get the cops out when the kids were actually smoking or just to sit in an unmarked car and catch a few kids and make a test case.

**1640**

I don't want all the young kids to go to jail. I want a few of them to set an example for the others, "Look, if you're under 16 or you're 12 years old and you're smoking, you might land in jail like this other kid." This is what I want. I don't want to jail all the kids or have them all have criminal records, but I want something that will prevent a kid from passing cigarettes to another kid, because the parents don't know what's going on in the school yard; they don't know what's going on on the way home.

I saw one kid passing a pack to the other kids and the three of them lit up, and they weren't 16 years old. You know what I did? I rolled down the window of my car and I said, "You're not 16, you're not allowed to smoke, and if I catch you again, I'm going to call the police." But I can't just roll down the window and do this every time. It's not my job. I was very annoyed because for 20 years I've been trying to get one kid or two kids as an example so that we wouldn't have this problem.

This is why I question why you aren't doing something so that the kid who's in possession—the law says if the parents write a note, the kid can go in and purchase cigarettes, and that's not good enough for me.

**The Vice-Chair:** Thank you for your presentation and the supporting details that you've given us.

GRAHAM STEBBINGS

**Mr Graham Stebbings:** Good afternoon, Mr Chairman and members of the standing committee on social development. My name is Graham Stebbings. I'm the owner-operator of five pharmacies in the Ottawa region. I'm also the representative to the council of the Ontario College of Pharmacists for district 1, representing over 650 of my colleagues.

I appreciate this opportunity to make this presentation to you because I want to review some salient points, all of them critical to the issue of the sale of tobacco products in pharmacies. This is the only issue in Bill 119. Were it not for the segment calling for the prohibition of tobacco sales in pharmacies, this legislation would have the support of everyone.

However, prohibiting the sale of tobacco in pharmacies is an extremely serious step and by now you've heard a great deal about it. You have heard how in June 1991, the council of the Ontario College of Pharmacists recommended the removal of tobacco from pharmacies, and you have heard how in August of that year, the elections to the council replaced eight of the councillors who voted for the removal of tobacco. I was one of those people elected, ousting the president under whose tenure the

decision to remove tobacco was taken.

You have heard how the council is composed of 16 elected pharmacists and six lay councillors appointed by the government, plus the dean of the faculty of pharmacy. And you have heard, no matter how often a vote in the council is taken on the issue of tobacco, how divided the council is. You have also heard that if a vote were taken among the 16 elected pharmacist members, the resolution to remove tobacco from pharmacies would be defeated. It is clear that the division in council reflects the division in the profession.

You have also heard from a variety of legal sources, your own and that of the college itself, that the issue of tobacco sales in pharmacies is not within the jurisdiction of the college.

You have heard the economic arguments: loss of over 2,700 jobs; loss of sales leading to pharmacy closings; loss of provincial tax revenues.

You have heard how prohibiting tobacco sales in pharmacies will compel some retailers to choose between selling tobacco and licensing pharmacies, how the decision will be made on the basis of economics and how the likely decision will put the jobs of pharmacists and dispensary assistants at risk, as well as those of other full and part-time employees.

You have heard further that the definition of a pharmacy in the legislation is seriously flawed. It is flawed because you are trying to define a pharmacy beyond the scope of the Health Disciplines Act and beyond the jurisdiction of a pharmacist as contained in the Regulated Health Professions Act.

While one of the functions of the College of Pharmacists is to accredit pharmacies, that accreditation is confined to the area where prescriptions are compounded and dispensed.

Bill 119 is in effect proposing that a pharmacy is not some 1,000 square feet but a huge area, possibly a multilevel department store that happens to have a pharmacy, or 75,000 to 100,000 square feet of space in a mass merchandiser or food store where no prescriptions are compounded or dispensed.

Let me remind you that the College of Pharmacists recognized the definition of a pharmacy—that it does not include the front shop—when it fought for and successfully obtained an amendment to the Regulated Health Professions Act based precisely on this notion that pharmacies would only be responsible for sexual abuse that occurs in the dispensary, not anywhere in the retail part of a store that could potentially be a five-storey building.

You have heard about surveys and you will no doubt hear about more of them. For example, there is a group known as Pharmacists in Support of Bill 119 that has conducted yet another survey which will be presented to you. However, the pharmacists of Ontario have already spoken loud and clear.

There is only one legitimate and acceptable survey and that is the one conducted by the Ontario Pharmacists' Association, which represents the economic interests of all 8,000 pharmacists practising in this province. That

survey found 62% in favour of continuing the regime of having the decision to sell tobacco a voluntary one, to be left in the hands of the professional pharmacist-owner.

All other surveys presented to you do not have the sanction or the legitimacy of the Ontario Pharmacists' Association. Not even the Canadian Pharmacists' Association survey is accurate; it was conducted with a small sample and it's not Ontario-based. I repeat, the Ontario Pharmacists' Association survey is the only accurate representation of pharmacists' attitudes in Ontario.

You have also heard that removing tobacco from pharmacies will have absolutely no impact on reducing the number of people smoking or the amount of tobacco consumed. People will simply go next door and purchase their tobacco from the myriad retail competitors to pharmacies that abound in Ontario.

Let me tell you what I have heard from my constituents, the people who have elected me on two occasions now and who depend on me to present them. Some of my colleagues who do not sell tobacco—I stress that, do not sell tobacco—tell me that they deeply resent government telling the profession what to do. They are concerned that if it's tobacco today, what product will it be tomorrow?

I have also heard from pharmacists practising in non-traditional format stores, stores which happen to have pharmacies contained within them. They are worried that if there is a decision to be made between pharmacy and tobacco, it will be the pharmacy that goes. It will be a decision over which they will have no control whatsoever.

Many of my colleagues tell me that they feel they have been unfairly singled out and their livelihoods are at stake. They assert, as I do, that pharmacy is both a profession and a business.

They recall that when discussions between government and the profession about fees were taking place, pharmacists were told that they must subsidize the decrease in the Ontario drug benefit fee by relying on sales in their front shops. In other words, we were specifically told that there was a distinct difference between the retail portion and our dispensary.

Now the retail portion of pharmacy is being attacked with this legislation, and it hardly seems justified or fair, particularly in view of the fact that so many products conventionally carried by pharmacies are now obtainable from so many other retail establishments that will benefit from the ancillary sales that accompany the tobacco they sell.

So I ask you: What will the government have achieved by this legislation? There will be no positive health impact; there will be jobs lost, services curtailed, some pharmacies closed. And for what?

1650

The long, drawn-out battle over this issue, one which has divided our profession, will continue and be exacerbated, because all of us know that we are nowhere near the end of this matter. It is a certainty that this legislation will be challenged in the courts, and that will further prolong and intensify the divisiveness that now characterizes our profession.

If government were serious about curtailing the availability of tobacco, especially to young people, it would remove the product from all private hands and confine its sale to controlled outlets, like liquor or beer. My constituents would support that overwhelmingly and wholeheartedly.

But what is the government doing instead? It appears to be getting at the tobacco companies by hurting a large drugstore chain that is supposedly tied in with a major tobacco manufacturer. In the process, it is hurting the independent community pharmacist, who represents the majority of pharmacists in this province. These are my constituents.

As one community pharmacist asked me to say, "Is this government so intent on punishing the largest drugstore chain in the province that it will sacrifice the economic survival of many independent pharmacists?" Surely this is not your objective and intention. However, you certainly seem to be doing just that.

For well over a century, pharmacists have been on the front line of health care, delivering quality services and excellent products to the citizens of this province. We have been united in our purpose and in our profession.

In the process of generating this legislation, in the fuelling of the controversy surrounding the tobacco issue, government is hurting the good name of my colleagues in the profession and the reputations of those I represent. All of this is deplorable and completely senseless.

I'll be pleased to answer any questions.

**The Vice-Chair:** Thank you. The parliamentary assistant wishes to clarify some items.

**Mr O'Connor:** On page 4 of your brief there, the fourth paragraph down, you said, "While one of the functions of the Ontario College of Pharmacists is to accredit pharmacies," and that area is confined, that's not always the case. This committee has been told by the college—we've had a discussion with the college around that and that was actually raised—that in some cases the entire pharmacy is part of it. What the college, in my recollection, was saying—because they'd like to see the total removal—was that it would then create a level playing field for all pharmacies, which includes some of those in which all the premises are part of the pharmacy. Not always are all the premises part of the pharmacy.

**Mr Stebbings:** In the basic function of the college, in accrediting the pharmacy, it accredits the area where the prescriptions are compounded and dispensed. When you take a retail establishment, you have to be clear as to whether you want to count the whole store as the pharmacy or just the area which is used for compounding.

There is a diversity of opinion as to what that is. In the sexual abuse case, where we said, "What is going to be a pharmacy; where are we responsible?" we clearly stated that we only wanted to be responsible for the area where prescriptions were compounded and dispensed.

We can't have a double definition, so where is the point of our jurisdiction, and what happens when you do have a large store? You have a Zellers, say; Zellers have pharmacies. Zellers is a large store. They have housewares at one end and a pharmacy at the other end;



tobacco on one side, clothes on the other side. Is the jurisdiction over the whole area? When you have a multilevel store, where is the jurisdiction? Do we count where they sell pots and pans as pharmacy too?

**Mr O'Connor:** I just wanted to clarify that. I think in fact there may even be an A & P where the entire store has been accredited as a pharmacy.

**Mr Stebbings:** Quite possibly.

**The Vice-Chair:** Are there any questions at this time? Mr Sterling. Welcome.

**Mr Norman W. Sterling (Carleton):** Thank you for coming to our committee. I find your brief lucid and well laid out.

I'm interested in the licensing aspect of selling tobacco. I once brought a bill in front of the Legislature to try to implement that kind of regime, and in order to avoid the bureaucracy which the government complains about in doing this, the legislation said that a vendor's permit will initially be your licence to sell tobacco, and part of the penalty, if you are caught or convicted of selling to minors, would be that your vendor's permit would then be appropriately altered so that you no longer could sell tobacco. It was a way of doing it, and as a Conservative, I'm not interested in creating huge amounts of bureaucracy, application fees etc, but I'm interested very much in controlling the sale of tobacco, to minors in particular. I would prefer to see that than dealing with the pharmacies.

I haven't been sitting on this committee a great deal—I was only involved on the first day, because I've been involved in other committees—and I quite frankly find this whole debate as to whether pharmacies should sell tobacco or not sell tobacco really a debate which is taking us away from the central issues. I've got to tell you I am upset that we're going on a road show and travelling around this province to talk about whether cigarettes should be sold in pharmacies or not sold in pharmacies, because I don't think it has anything to do with our young people or our old people smoking more or less.

**Mr Stebbings:** You're absolutely right, sir. We have a situation where the government wishes to bring down a policy of legislation. The legislation as it is formed at the moment doesn't achieve the end, because if you want to reduce smoking and if you really want to stop minors smoking, you have to have some control over the selling of cigarettes, of tobacco. Cutting out one retail establishment does not achieve that, because there are too many retail establishments out there which are selling tobacco.

What you really want to do is give your bill some teeth. What you really want to do is say, "We will have a licensed outlet which is controlled." There is no control here about a mom-and-pop store on a corner. I can tell you that pharmacies are probably greater controllers of tobacco sales than any other outlet. You know, it seems a little ludicrous, but in pharmacy we are sanctioned to sell drugs. We'll sell morphine, we'll sell codeine, we'll sell Demerol, we'll sell narcotic drugs. That's our licence. Nicotine is a drug. If you really wanted to control nicotine, you could put it within the control of a phar-

macy and cut out all other licences.

I've heard this afternoon great debate about pizza stores selling cigarettes via delivery. I've heard about vending machines. I personally don't smoke. I see small grocery stores which would sell to anybody. Right now, until we reduce the taxes, there are people openly selling cigarettes in school playgrounds, on corners—contraband cigarettes.

**1700**

Here it's even nothing. You need teeth in the bill. It's ludicrous. I know in that we're a little bit hypocritical, because while the government still accepts tobacco taxes, it cannot say it's doing something to stop the consumption of tobacco. If the government is to do something, it must first look at its own house and its own financial status and say, "We're willing and want to do without it."

To control it to children, to minors, I really feel that you have to have a controlled outlet. Part of my submission here is based on the accompanying sale. We've heard pharmacists this afternoon saying that to them it's not a large economic impact. It is a large economic impact. I own pharmacies; I know. If you have a level playing field where nobody sells tobacco other than a special licensed outlet, then that economic impact, or the loss of accompanying sales, is decreased and the viability of those retail outlets is maintained.

**Mrs Yvonne O'Neill (Ottawa-Rideau):** We've had a very interesting day today. It's not been like the other days. From the presentations we had both in Toronto and here and a conversation I had last night with a manager in the Hudson's Bay Co, I feel that as legislators we'd better be responsible and come up with a definition of pharmacy. The person I spoke to from the Hudson's Bay last night tells me the cigarettes are sold on the main floor of the store and the pharmacy's on the fourth floor of the store. Is that going to have to be a choice that store, which occupies one of the main corners in the city of Toronto, is going to have to make?

There's just no rhyme or reason unless we can define what pharmacy means. I think the public, and I certainly think the owners and other retailers, have a right to know what we mean by pharmacy. We're finding that the complex definitions are now coming forward, and they're going to get more complex, as we were reminded this morning, when Wal-Mart comes in. So that's one thing, and I hope the government is going to be willing to give us a definition of pharmacy. We're either going to go by the regulated health professions definition, we're going to take another province's definition; we're going to do something, I hope, to come forward.

I sat through the Bill 100 hearings, and they were, I would consider, within the five most difficult sets of hearings I've been through, because professionals were on the line, and they were serious hearings. The definition of pharmacy in that Bill 100 is very different than the one we're being asked to abide by here. This is the same government, and I really don't see how we can be expected, in opposition or even as legislators in the government, to accept a definition in one bill and a different definition in another bill. The public of Ontario deserves better, so we better come up with it.

The second thing I was disturbed about this morning, and I am still disturbed about—and I want to state publicly I'm very sorry that our Minister of Agriculture and Food has had a serious accident. No doubt his parliamentary assistant and others will be able to provide the information, but I really do think this committee should have an update on what the plans are for tobacco farmers who want to get out of this business. Has there been a total hiatus? Are things not happening there? Are programs that were on the books not somehow moving? I think this committee has a right to know we are not just tackling this from one particular perspective and just in one particular way.

The federal Liberals have been criticized because they lowered tobacco taxes. They did other things as well, and unfortunately many people haven't heard of the other four things that were part of the program.

I would like us to be able to have a clean slate and say, "Yes, we have tackled this and our message is consistent," whether it's the definition of pharmacies, whether it's helping people who want to get out of the business, whether it's providing compensation for people who are going to go bankrupt—and I think they may have to provide business plans to prove that—but we have got to have some more teeth to this bill and we also have to have a transition period for people's lives who are going to be affected. I would like to have some clarification, and I want the clarification about the Ministry of Agriculture transition programs in writing and I want the definition of pharmacy in writing.

**Mr Stebbings:** I think Mrs O'Neill is correct in what she requires for your committee. I think you have a myriad job in front of you to define what will be the economic impacts and where the jurisdiction lies.

**The Vice-Chair:** Thank you very much for your presentation. We appreciate it. Parliamentary assistant, did you wish to respond to Ms O'Neill? The questions then will be tabled.

**Mr O'Connor:** They're tabled and they're on the record. I have them and I appreciate her concerns.

**The Vice-Chair:** So we will have answers to those questions at the next meeting.

That completes the hearings for this afternoon.

**Mr McGuinty:** Just briefly, I'm not sure if other members have been provided with copies, but I've received letters from York Student Centre, Mohawk College Student Union Corp and the students' council for Western expressing concerns about the definition of "post-secondary education," I guess is the wording used in the bill, and that's something else that obviously we're very concerned about. Concerns have been raised about whether smoking would be prohibited on campus: bars, residences, restaurants, which are presently subject to bylaws. Bearing in mind that the intent here is primarily is to make it harder for kids to start smoking, I'm not sure how a campus-wide ban would achieve that goal. What it would do would be drive business on campus off campus. So I look forward to a definition of the post-secondary situation.

**The Vice-Chair:** Two of those representatives indeed

were present this morning but didn't have the opportunity to make a presentation. Parliamentary assistant?

**Mr O'Connor:** I do believe that yesterday while we were on the record, and maybe Mr McGuinty was out of the room at the time, I did offer some clarification. We did hear from some people, and it will be clearly in the record. If he was out of the room at the time, I hope maybe he'll have a chance to review the Hansard.

I'm going to be addressing the students directly. We did get approached by a few today, and I appreciate that, and I think all committee members have been copied with that information and appreciate you raising it and perhaps you'll find some of your answers in Hansard already.

**The Vice-Chair:** We will recess until 7 pm.

*The committee recessed from 1708 to 1903.*

CAROLYN BURPEE

**The Chair (Mr Charles Beer):** Good evening, ladies and gentlemen. We begin our evening hearings in Ottawa with Carolyn Burpee, the owner and pharmacist of Kemptville Guardian Pharmacy.

**Ms Carolyn Burpee:** Thank you for the opportunity to come here and give my opinion. I am for Bill 119. There's one thing I want to say. I'm not sure how to say this, but at the 4:30 presentation, Graham Stebbings was here. He doesn't represent myself or some of my other colleagues, I wanted to say. I thought he was supposed to be representing his Throop Group and I felt in his presentation that he mixed up OCP along with what he was representing.

Anyway, my whole stance here this evening is very short. It's really as a pharmacist and a pharmacy owner. I believe as a pharmacist that I am a health professional. I've been in this business for 22 years. I was a nurse before a pharmacist. I've been in hospital pharmacy; I've done a residency in hospital pharmacy. As a health care professional I believe that I'm in a position of trust, of responsibility. We must walk the walk, as I said in my presentation there, and not just talk the talk. To me, to sell cigarettes in pharmacies gives a very mixed message.

My credibility as a pharmacist, a health care professional, I believe is on the line. I'm there every day. I am the owner of the pharmacy but I dispense every day. I'm there, I counsel patients, I see them with their inhalers. I know a lot of these people are smokers. For them to go to the front of a pharmacy and then buy cigarettes, or cartons of cigarettes, just to me gives a really mixed message.

My concern is with young people. There are a lot of young people. I'm an ex-smoker too so that I know that when I smoked I used a lot of excuses and rationalizations about smoking. I don't want to be part of that for young people to say: "Well, you sell it in a pharmacy. It can't be that bad." I know that people do say that. I've talked with people. I've talked with young people.

Anyway, that's that part of my presentation, but the other part is as a pharmacy owner. I am well aware that we have a bottom line. I have a business, I have people to pay, I have myself to pay. This margin, I know, has dropped a lot in the last couple of years, and I have a concern about my fellow colleagues who say their stores



would go out of business if they don't sell cigarettes. I guess I would really like to see their profit and loss statements. I really don't understand that. We sold cigarettes in my pharmacy and took them out in 1987. It represented 10% of our sales. It took us a little over a year to recoup that. We put in health-related items.

To say that pharmacies are going to go out of business if they don't sell cigarettes, I don't know, maybe they should be a tobacco shop and not a pharmacy. I don't see that we can sell cigarettes and still be credible. Cigarettes interfere with medications. A lot of people who smoke, there's a lot of problems with them on theophyllines, all kinds of medication. They metabolize it a lot faster, the dosage is different.

It really upsets me when I see on TV some of these bigger companies and they talk about a fair playing field. I'm just a little fellow but I am operating a viable business. They advertise about their computerized systems that can check for drug interactions and all kinds of things. We all do that, we all have computers, but the public believes a lot of what they see. Then they go in these stores and they sell cigarettes and they say, "We really do care about your health." To me that's a mixed message; you care about their health but you hand them cigarettes on the way out.

I feel that as a pharmacist we can't sit on the fence any longer. Are we in or are we out? We are a health care profession. There are a lot of services that we provide on a daily basis. There are things that we do where maybe we could negotiate with the government or with third parties that we could get some type of reimbursement for those duties; I don't know.

But to sell cigarettes and for that to be part of the solution of our decreasing bottom line I think is inappropriate. It lacks integrity and responsibility because we have a position of trust. How can anybody trust me if I'm going to sell them cigarettes on the one hand and on the other hand say, "You know, you shouldn't be smoking," or whatever? To me it's a really mixed message and I feel very strongly about that.

1910

**Mr McGuinty:** Thank you, Ms Burpee, for coming in to see us and making a presentation. You should know that all of the committee members here, and I speak without hesitation in this regard, feel very strongly about developing a comprehensive plan to address the tobacco problem in the province, and particularly in so far as it affects our young people. This bill, I think, is going to go a long way towards dealing with that.

You will also know that a controversial aspect of the bill is the one dealing with the pharmacy ban. We are, I think understandably, a little bit confused because we're getting conflicting messages from different pharmacists. I'm sure that you would agree with me that it would have been much better had pharmacists been able to work this out among themselves.

I'm just wondering—I haven't asked this question of anybody else—after this becomes law, is there anything that pharmacists can do further that they're not doing right now? They are on the front line, particularly in

terms of helping those people who are addicted to cigarettes at this stage. Is there anything that they could do, any role that they could play that they're not now playing in terms of being a bit more proactive?

I understand right now, of course, if I understand the role of pharmacists, you're behind the counter and you have to wait until somebody makes an inquiry: "Listen, I'm hooked on cigarettes. Have you got anything there that'll help me?" I'm just wondering if there's some way we can harness that human capital there, the pharmacists, in terms of dealing with this problem a bit more proactively. I'm just throwing it out.

**Ms Burpee:** What I do at my pharmacy is that I share my experience with people who smoke, because I think that they shouldn't give up because they've tried it and they haven't succeeded; they should go back and keep trying until they do succeed. But I have pamphlets on when they do quit—associations or smoking cessation courses that they can take—that are available there.

I don't know unless you mean you'd be more active in the community. I do counsel people when they use patches or when they come in to buy their Nicorette gum. I think it's very important they know exactly how to use that—not as a gum—and take time to explain that to them, because if they don't know how to use it properly and what to expect, then they may not be very successful and they'll give up too quickly.

**Mr McGuinty:** Maybe I'm just thinking of something like—maybe you have something like this now—some kind of a cessation program that doesn't involve gimmicks, doesn't involve selling a particular product, but some countdown or pamphlet or something put out by the college.

**Ms Burpee:** Right now I know some of them have—and we could be involved in that, I think—a certificate where you say, "This is what I'm going to do," and then we could do some type of follow-up, perhaps something like that, if that's what you're thinking of. Have them come back in two weeks to the pharmacy to see how they're doing or perhaps we'd call them to see how they're doing, to keep in contact.

I think one problem right now is that there isn't any follow-up. People sort of go and they do it and that's it. It's not just putting on that patch; it's not just chewing that gum; it involves behavioural changes as well. There has to be some link.

I, as a pharmacist, can't give you an exact process, but I would be very willing to be involved in that, because I think that contact is very important and I don't know that it's that available at physicians' offices, because they are pretty busy. But we could set that up as a system. I'm sure in pharmacies we could.

**Mrs Cunningham:** Thank you very much for coming before the committee this evening. Since you're here and the issue of pharmacies is something that we've listened to a lot—basically this bill is intended to prevent the provision of tobacco to young persons. I'm wondering, in your experience, if you would go so far as to say that persons who sell tobacco should be licensed or, even further, to say that perhaps it should be sold in LCBO

outlets, meaning tobacco. Really, if we took your submission and we said that you can't sell it in drugstores in all of the legislation, I'm not sure that anybody has proven that there would be less tobacco sold to youngsters. Those retail pharmacists made that point, by the way. So maybe we have to go further than that. We've got large fines, but right now we know that we are not enforcing the existing law, which says it's illegal to sell. I think this bill needs more teeth and I wonder if you have any advice for us.

**Ms Burpee:** I feel strongly it should go into like an LCBO. I think that's where it should go and that it shouldn't be left out there.

**Mrs Cunningham:** What about a licence? Otherwise the penalty would be that you lose your licence.

**Ms Burpee:** I think it should be that strong, because now it's not enforced, is it?

**Mrs Cunningham:** It's not enforced, in my opinion. I represent London North and they tell me it's not enforced. You're there and you must know in Kemptville, for instance, if anybody has ever suffered any fines for illegally selling tobacco. I don't know what you're going to say to that. Have they?

**Ms Burpee:** No. I think it should be licensed and in LCBOs, that type of thing.

**Mrs Cunningham:** Maybe we didn't need any legislation; we could just enforce what we've got.

**Mr O'Connor:** Thank you for your presentation here this evening. I know that we've heard from a lot of people, and there's no doubt in my mind, from all the work that I've done with people in the community, that there is definitely strong need for this legislation as well as the other components of the action on tobacco. A Premier's Council said we've got a problem. The chief medical officer of health came out very strongly and your college has been quite strong and for a couple of years has been trying to convince people they should be moving in this direction.

We had the opportunity to hear from a couple of pharmacy students, and they get a very mixed message when they've been watching these hearings. We actually got a written presentation following the presentation from the graduating class from this year. I'm sure that as they look at this evening's Hansard they're going to be able to take a look at, for example, what you've said and the role that pharmacists can play in health care, because that's what they see themselves as graduating to do, to provide that health care; not to be the retailer, knowing that's part of it, but the health care. They're in there and they're going to be involved in the cessation.

I think that we'll probably see some stronger linkages to a lot of the coalitions that are out there working in the community. Government alone can't do it and nowhere did the government say that it can do it alone. It's working with even our friends from the media, talking about this issue; it's working with people in the community as well as with people that work in the community.

**Ms Burpee:** We're in it together.

**The Chair:** Ms Burpee, thank you very much for coming before the committee this evening.

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GEORGE GEORGEWILL

**Mr George Georgewill:** Thank you, Mr Chairman and members of the committee, for the opportunity to present my support for Bill 119. My name is George Georgewill. I own a pharmacy in Ottawa. I studied pharmacy in England and I've practised pharmacy in Canada since 1989. I opened a pharmacy two years ago.

I am here to support Bill 119 because I think it will do a few things. First of all, if pharmacies stop selling cigarettes it will send a clear message to young children out there and even those who are smoking right now, even the elders, that we pharmacists realize that cigarettes are harmful to them. By selling them we are sending a very simple, short, conflicting message that we think cigarettes are good. It should be clear from us pharmacists, as professionals, that cigarettes don't do them any good.

Before I go further I would like to ask two questions both to pharmacists and non-pharmacists who oppose this bill: Do they consider pharmacists as health care professionals or do they consider pharmacies as health care facilities?

In my opinion, if the answers to these questions are yes, then we shouldn't sell cigarettes because it's contradictory to what we are supposed to be doing. We're supposed to serve the public, care for their health, and if we intentionally give any product that is not good for your health, then we are going contrary to what we are supposed to be doing.

A few of the people who oppose this bill have raised certain questions. One is loss of jobs from pharmacies if they stop selling cigarettes. I started my pharmacy at the height of the recession. It's a small pharmacy, I have not sold cigarettes and I'm still having a viable practice. I don't buy that argument.

Some people are opposed because they say the legislation is trying to legislate on everything in our lives. I think they should when it's necessary. Right now, as you all know, you are legislating on drinking and driving because it kills. I don't think it kills more than diseases associated with cigarettes. Is it because we don't see the figures or we don't see the physical action? We see the physical action in drinking and driving and getting involved in accidents. Cigarettes and associated diseases kill more. So why shouldn't the legislators get involved?

Thirdly, some argue that corner stores will be the beneficiary of stopping selling cigarettes in pharmacies. They carry on good businesses. I oppose that because I don't think we should be comparing ourselves with the corner store. If we are health care professionals, we do have responsibilities in the communities we serve. I do not mean that the convenience stores do not have responsibilities, but our responsibilities are a bit different. We care for the public's health. We dispense drugs. We have the monopoly to dispense drugs. They don't do that.

For example, pharmacies are being trusted to sign as guarantors on passports, which is a big responsibility. I don't think any corner store has that responsibility. We should realize that we're being respected in the commun-



ity in which we serve. Every time we go to meetings every pharmacist is very happy when he sees that pharmacies are being regarded as one of the most trusted professionals in the communities. We are all very happy. How does it come? I believe we should sacrifice certain things to maintain that credibility in the community we serve. We know that cigarettes don't do any good, and if we continue selling cigarettes, we're telling the public out there that we know the facts but because of economics and wrong information we will continue to sell a product that we know is very harmful.

Every time I watch the news I see on the TV some drugstore chains, pharmacy chains, the big stores, and they advertise their health watch, how they watch drug interaction, how you would rather be in the computer than be in the ambulance. That is our job. We're supposed to watch what our patients take. I know and every pharmacist knows there are a lot of diseases associated with the use of cigarettes. They are not less harmful than drug interaction. If we will watch for drug interactions, I don't see why we shouldn't watch for the use of cigarettes. Cigarettes affect every medication most patients use.

One of the members, I think Mr McGuinty—sorry if I have mispronounced your name—asked the previous speaker what pharmacies could do. Yes, pharmacies could do a lot. There are a lot of programs out there; for example, right there is a program right now that supports people who want to stop smoking cigarettes. There are a lot of programs around the Ottawa region. I don't have the pamphlets, but if you want I'll send them to you, of programs that are right now helping people who want to quit.

I personally in my store have a list of people who come to buy Nicorette. I talk with them, I spend time with them and I make sure that as time goes on we reduce the amount of Nicorette gradually to suit their purpose. I do that. If you want those I'll send them to you.

Those are some of the things that pharmacists could do. We can even do more. It should be a challenge to our profession that we should get involved. If we stop selling cigarettes, then we have the credibility to go out there and support those who want to quit.

I have a few suggestions as well. One of the members, Mrs Cunningham, asked the question if licensing should be a way. I think so. I think by licensing we don't lose anything. The province can license, collect money from those who want to sell cigarettes, and it can use that to pay inspectors and establish a bureau so that the enforcement could be carried out. So I don't think it's going to cost the province much.

Secondly, I will even go further to suggest that cigarettes be classified in the same situation as alcohol if enforcement will be a problem, so there have to be specific places to buy cigarettes, just as we buy alcohol. I don't even think alcohol is more dangerous than cigarettes.

There's a question I want to pose to pharmacists and non-pharmacists who oppose this bill, especially the politicians as well. If any of us or any of you or any of

the pharmacists who oppose this bill know right now that most of your south constituencies that have maybe 13,000, 18,000, 20,000, if you know that 13,000 of your constituency will be dead by the end of the year from a preventable illness which you can do something about, wouldn't you do something? I will, and that's why I don't sell cigarettes. Thank you, Mr Chairman.

**Mr Jim Wilson:** Thank you, sir, for your presentation. I should begin by saying that I don't know of any political party or any politician who isn't going to support this bill. Everybody supports it. We just have a problem with one particular clause in the bill that we're having a great deal of debate over, as you can imagine.

**Mr Georgewill:** That will be nice to hear.

**Mr Jim Wilson:** It's the record, and all parties supported it on second reading. It's motherhood. No politician's going to not support this bill. But you're correct in saying that there's a difference in view among the pharmacy profession and among some politicians. We disagree and I guess some of us see this clause as a freedom-of-business issue.

You have to remember where we're coming from is three years of a lot of this sort of stuff from this government. Unfortunately, it's blown up in a health care field and it shouldn't be. We shouldn't have to confront these business issues in a health care field, but we've had three years of this stuff, culminating in particular with the labour laws last year.

There will be some job losses. I just want your comment on that because you didn't think there would be, and I'd say in some of the smaller pharmacies there probably won't be. But A&P, the grocery store chain, made it very clear in its presentation that if it's a toss-up between keeping the pharmacy at the back of the store and the cigarette counter at the front, when it comes to bottom line in profits their business decision would likely be to close the pharmacies. Zellers made a very similar point, as have many of the other large retailers.

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We're seeing pharmacies evolve into larger retail entities. We're going further and further away from the small town pharmacy that just dispenses prescription drugs, OTCs and provides health care advice. I'm just wondering—a question to you since you asked us a few questions—whether you think pharmacists should be allowed to be full-fledged retailers.

**Mr Georgewill:** It depends on what you mean by full-fledged retailers.

**Mr Jim Wilson:** They're selling everything in Zellers these days, yet this bill calls Zellers a pharmacy.

**Mr Georgewill:** I think that would be one of the suggestions, that they should not have a pharmacy or sell cigarettes under the same banner as a pharmacy.

**Mr Jim Wilson:** But my question was, should they be retailers? Because if we can get into the question whether the government should tell retailers whether or not they can sell particular products or not, it reminds me of some other countries I didn't think I'd be living in.

Just on the retail question, though, if they're going to continue to expand and start to sell tires and automotive

parts and everything—you have to understand one of the reasons we have a problem with this bill, as you know, is that the way it's written that entire Zellers store, because it has a pharmacy in one of its 16 departments, cannot sell cigarettes. It's considered a health care facility. I have a real hard time, if I'm standing in the jeans section, figuring out that I'm in a health care facility. That's one of the reasons we don't support this. What the bill says to me is that pharmacists shouldn't be retailers.

**Mr Georgewill:** If I understand your question, if they want to have a pharmacy, they want to have a pharmacy. Then they shouldn't be under the Zellers banner. They should have a pharmacy separate because a pharmacy, as I have said before, is supposed to be a health care facility. They can sell whatever retail products they want to sell. I guess it comes with the argument that they can monitor the sale of cigarettes. I have worked in Shoppers before. I had no clue when somebody went to the front to buy cigarettes. I was always at the back. So that argument, to me, doesn't work.

**Mr Winniger:** Thank you for your very sincere presentation. Your remarks have certainly gone a long way towards dispelling some of the myths we heard about the economics not permitting small pharmacies to take tobacco products off their shelves or that it's discriminatory to prohibit tobacco sales in pharmacies when other stores can do it and also arguments we've heard that if there's enough space in between the shelf with tobacco products and the drug dispensary, then it's okay to sell them.

I did hear, though, that you were educated in England. According to Physicians for a Smoke-Free Canada, tobacco cannot be sold in pharmacies in Australia, Sweden, France, Belgium, Israel and Argentina. I'm wondering what the case is in Britain.

**Mr Georgewill:** Actually, two days ago I spoke to a colleague of mine at the British Pharmaceutical Society. They don't. It's against the code of ethics to sell cigarettes in pharmacies.

**Mr Winniger:** So it's not permitted?

**Mr Georgewill:** No, it's not.

**The Chair:** Thank you very much for coming to the committee this evening. We appreciate your presentation.

PAMELA NEWTON

**Ms Pamela Newton:** Good evening. I will digress immediately and mention that in Britain, Safeway food-drug combinations have pharmacies in their Safeways. There is a big food store and then they have a separate area and they have their pharmacy right in there. They have food-drug combinations in Britain.

Anyway, I'm presenting on behalf of Girdwood Guardian drugstore and I represent no other interests; I'm a lobby of one person. Over the last 19 years I've been a pharmacist at Girdwood drugstore. I've owned the store for many, many years. This store is in a small Ontario town. It's been a drugstore for 148 years, and over the years it has responded to economic pressures and competitive pressures.

We've extended this store from one street right through

one block to the other street. This is one of the main reasons I'm here tonight to speak to you. You see, we span one block. At one end of this store, which is 198 feet long, we sell tobacco, candies, other kinds of junk, and way at the other end of the store, adjacent to our car park, for our senior citizens and for the people who are looking for their medical treatment, we have our pharmacy department, we have extensive counselling, we have all our health products, all our pharmaceutical products gathered together at the other end of our store. In the middle of our store we have a large office supply department, we have gifts, we have cards, we have a post office, we have cosmetics.

Now, in effect, we're running a diverse retail operation. It's a very serious drugstore. It's a very big part of my business and it is my major interest. However, we run all these other departments because we are intending to stay economically viable.

The thing with this is that the store layout of our store is such that we could put a dividing wall, we could put barriers, we could put turnstiles, we could put a little mall in the middle and I could run the pharmacy at the back, somebody else could run all the other stuff at the front, and we could house this in the building which we own, over which we have complete control, which would be run by a holding company.

We are a small drugstore when you look at the competition. When you look at Shoppers Drug Mart and Pharma Plus and Zellers and Wal-Mart coming in, we're small potatoes. The fact is that if we wished, which we don't particularly wish to do, because cigarettes represent only about 1% of our business and we are intending to scale them out because there are other things that we wish to do, but the fact remains that if we wished to do so, we feel that we could run both cigarettes and pharmacy products.

Listen, I'm small. If I think that I can do that, you may rest assured that the large food-drugstores, the large combination drug companies know that they're going to do this.

On the next few pages of my presentation, I'm going to expound on this further. You asked for us to summarize our conclusions to start with, so I will. I want to say on behalf of Girdwood Guardian drugstore that we conditionally support Bill 119 provided that sections 4(2)9i and 4(2)9ii are totally enforceable regardless of the size and diversity of the retail premises operated by the parent corporation. The enforcement is necessary to preserve the viability of smaller neighbourhood-focused drugstores that do not have the economic or legal capabilities to circumvent the spirit, perhaps even the letter, of the law.

We also wish to say that we do support raising the age to purchase tobacco to 19 and very much we support the banning of vending machine sales of cigarettes.

We have added an addendum. I can't resist this. We submit an alternative method of collecting tobacco taxes which could uphold tobacco tax revenue and eliminate the economic base for smuggling and eliminate the need for the tobacco export tax, which is going to be a real factor, because tobacco companies will continue to



manufacture their tobacco in the States and bring it up into Canada. Anyway, that's an aside.

The pharmacy acts of Ontario are designed to regulate the practice of pharmacy. They set standards of practice and they insist on qualified pharmacists in licensed premises. The other aspects of the pharmacy acts deal with the ownership of pharmacies and include the ownership of pharmacies by individual pharmacists and by corporations, and these can be corporations of any size.

The contemporary practice of pharmacy is located increasingly in a department of a diversified retail establishment, such as large food-drug-department stores. Our concern with Bill 119 is with the ultimate effectiveness of section 4(2)9i, which I'm sure you know of, and section 4(2)9ii. We feel that the above two clauses will be circumvented or will prove unenforceable in the mass merchandising environment in which retail pharmacy is now being practised, and it will be greatly to the detriment of neighbourhood pharmacies, focused pharmacies on health care.

For instance, company A can use a holding company to rent the retail space. You can subdivide this retail space—Safeway is doing it, Asda in Britain is doing it, Overwaitea is doing it out in British Columbia. Beyond the cash registers of your large food-drug conglomerate, you have your common mall, your common area, and then within this common mall area you have specialty kiosks and booths. These are leased to company A's subsidiaries or to franchisees' subsidiaries, anybody you like.

In this way, by a legal and a spatial separation in a large physical retail location, the concomitant sale of cigarettes and prescriptions will continue, to the financial benefit of the parent retailing company and, I do feel, to the detriment of the pharmacy profession. I underline that most sincerely. I feel the Ontario College of Pharmacists doesn't realize how detrimental this will be to the practice and the profession of pharmacy.

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Many drugstore businesses are not just pharmacies exclusively. Of necessity, many drugstores are providing a wide range of diverse products to offset the impact of diminishing margins in the health fields and to offset the impact of larger food-department stores, which are selling products that were traditionally considered drugstore items. A lot of drugstore items are now being general-product-listed. This is making a very big difference to pharmacies.

Unless controlled by laws that also control drugstores—in this case, just when is a large store with a pharmacy somewhere in it subject or not subject to the same laws as a drugstore?—large organizations are going to erode the economic base that enables pharmacists to provide professionalism and service to their community.

If a diverse product line drugstore with a pharmacy cannot sell tobacco products, and I agree with that, then should a large food-department store that sells tobacco products also be permitted to operate a pharmacy within its premises? When does a large drugstore become not a

drugstore? When does a small food-drug-department store become a drugstore?

We agree, however, that in pharmacies, where sales and services are almost exclusively oriented to the provision of prescription services and health products, the sale of cigarettes certainly seems inappropriate. But the problem with this statement lies in just how does a legislator define a clause such as "almost exclusively oriented to the provision of prescription and health products" or indeed how would a legislator define what is a drugstore in Ontario?

Drugstores need a level playing field on which to operate their business. The question of whether to sell or not sell cigarettes is part of a larger question on how to remain competitive when other non-pharmacies can potentially operate pharmacy departments and still sell cigarettes. It is our contention that drugstores would be amenable to not sell cigarettes and not sell food products, provided that food stores and large multimerchandisers that sell cigarettes not sell prescriptions.

We sell cigarettes at present as a convenience to our customers. Convenience is one of the factors that makes us competitive, and competitive we must be and we intend to be. If we could be assured that we were not being put at a competitive disadvantage by Bill 119 being circumvented by our large competitors offering pharmacy services and cigarettes, we would enthusiastically endorse this bill instead of somewhat conditionally accepting it, as we are at this moment.

We anticipate phasing out tobacco sales from our store. It's financially not very important to us, and that's why I feel it's very important for me to make this presentation to you, because I don't have a very big vested interest in tobacco. Public opinion makes it somewhat compelling that we should, and we have other things that presumably we want to do with the space. But we don't consider that our proposed action is going to contribute in any way to the reduction of smoking by our customers. They're going to go next door, two doors down, three doors up, across the road or across the road the other way. However, we really resent being told what to do.

In conclusion, we do support the ban if—and we must underline this—the control of concurrent sale of drugs and cigarettes is enforced in all establishments.

My amendment, addendum—am I allowed to mention this? The current reduction in cigarette taxes which we know is now coming into Ontario, much to our disappointment, means that there are going to be increased taxes for all taxpayers. As non-smokers and payers of substantial business and personal taxes, we consider the latest trend of reduced taxes on cigarettes to potentially lay an even heavier tax burden on citizens today.

We suggest that consideration be given to a direct taxation on smokers instead of taxing cigarettes at a high level at the cash register. Taxpayers, at their own expense, could be medically tested in a manner found acceptable by insurance companies to determine smokers. Remember, insurance companies are doing this all the time to determine smokers as an insurance risk. Non-certified people, that is, smokers, could then be assessed an annual smokers tax to make up for the lost tax

revenue that is currently going to be occurring from the loss of taxes on retail cigarettes. That is right.

Cigarette smuggling simply would not be economic and it would disappear. The export tax on cigarettes would no longer be necessary and the governments, I am sure, are interested in keeping manufacture of tobacco here in Canada. Taxes would be collected from smokers and not from myself at a rate sufficient to equal the current prediscouted cigarette tax revenue. That is my submission. Thank you.

**The Chair:** The timing of your last proposal is perfect. We'll make sure that gets up to Parliament Hill.

**Ms Newton:** Good. Thank you.

**Mrs Haslam:** Thank you very much. It's been a very interesting proposal. I actually like it. I draw attention to the name of your store because it says Guardian Drugs, and I commend you for being that type of a store, wishing to remain in the pharmacy business. Even though you do have the tobaccos, you're actually phasing them out. That's what it's all about, looking at the health issues of tobacco for sale in the same store as health products.

The principles about this legislation and this committee working are the principles of health. It's not about telling stores what they can sell. We're looking at an addictive product, we're looking at something that kills 13,000 people a year in Ontario, and I think the principles are there in front of us to always look at the health care. Small stores will always have to battle with large stores; Zellers will always have to battle with K mart.

**Ms Newton:** If you're looking at it as a health issue you should ban cigarettes. That's quite simple.

**Mrs Haslam:** That's true and that has been suggested to us.

**Ms Newton:** If this a health issue, don't beat around the bush. You ban it.

**Mrs Haslam:** Well, that's been suggested to us; it has been. I'd like to go to your last page though. It was interesting that you mentioned direct taxation on smokers. I had a presentation of a woman in my office who said, "Why don't you put a tax on people who use the health care system who are smokers?" I wonder if you'd like to comment on that particular treatment.

**Ms Newton:** I disagree with that, because if you put a tax at the point where persons move into the physician's office or to the hospital, they will not go to their physician or to their hospital in time. If they realize that they're going to have a surcharge put on them at the time of their visit, they're liable to think: "I'll delay. Maybe I'll go in six months; maybe I prefer not to go; maybe I prefer not to be lectured to, really." That's the only reason I would not suggest that as a viable proposition.

**Mrs O'Neill:** Ms Newton, your point has been brought forward but I don't think as poignantly or maybe even as eloquently as you've done it tonight. You've obviously done a lot of thinking about this.

**Ms Newton:** I do a lot of thinking. It doesn't get anywhere, but I do a lot of thinking.

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**Mrs O'Neill:** Others have, as I say, gone on the

edges, and I have requested a definition of "pharmacy" for the bill. I haven't received that yet. Could you tell us a little bit about what you think could be done to the bill to make what is in it enforceable?

**Ms Newton:** I'm very pessimistic at this stage about making those two particular clauses that I'm pointing to enforceable. I felt more positive about it about three weeks ago. But having seen the federal government fall to the pressure to reduce tobacco taxes because of the problem with smuggling and the many ramifications of that kind of problem, I'm feeling increasingly pessimistic about the possibility of government really being able to face up to the tremendous lobbies and tremendous pressures that it's going to be facing.

I don't really feel very positive about the possibility of really enforcing this. I wish I did and I wish I could say that I thought it could be enforceable or that I could really think of bright ideas by which it could, especially in this current climate. They just haven't risen.

**Mr Sterling:** I want to thank you for your brief and I want to indicate to you that your member, Leo Jordan, has echoed the same sentiments—

**Ms Newton:** Maybe I've been speaking to Leo.

**Mrs Cunningham:** You've done a great job.

**Ms Newton:** I'm always talking to poor Leo.

**Mr Sterling:**—your same sentiments regardless about a level playing field for the small businesses as well as looking at the bigger ones. Have we been through this argument? Have we been through this mess before in terms of dealing with Sunday shopping and pharmacies? Isn't this the same thing we're sort of inviting again?

**Ms Newton:** Pharmacists like Sunday shopping, or they did. I don't open on Sundays. I wouldn't like Sunday shopping, but it did offer exclusivity to pharmacies, which they lost with open Sunday shopping.

**Mr Sterling:** Yes, but that was the argument: Where did the pharmacy end and where did the grocery start?

**Ms Newton:** They had this definition of 6,000 square feet.

**Mr Sterling:** But isn't this the same thing we're going to get into with smoking and the pharmacy?

**Ms Newton:** This is what I fear we are going to get into, where at some point it will be possible to say, "This business is primarily a pharmacy. This is primarily a pharmacy business and therefore should not be able to sell cigarettes," and because of the great difficulty of enforcing legislation against very strong and powerful organizations, there will become this division, some kind of cutoff point like the 6,000 square feet for the Sunday shopping that was there.

They will come this point where they say, "You're primarily a drugstore and that is your primary focus of interest," and in these stores the pharmacy is simply a well-run department in a big company and they're entitled to do this. I think this is going to come about simply because it's going to be so very, very difficult to apply and enforce this legislation.

**The Chair:** Ms Newton, thank you very much for coming down from Perth tonight. We appreciate it.



DON JONES

**The Chair:** I call on Mr Don Jones, pharmacist, the Riverside Hospital Pharmacy. Welcome to the committee.

**Mr Don Jones:** I just have a very short correction. I'm at the Riverside Hospital, but we'll get that straight.

**The Chair:** I'm sorry. Riverside Hospital Pharmacy.

**Mr Jones:** Yes. Looking over the list, it's interesting. I suppose I come to you as a non-retail pharmacist in my background, and my experience has been varied, looking at the presentation I've given you.

I am licensed to practise in Ontario. I've had a two-year post-graduate training in hospital pharmacy in conjunction at the Ottawa General Hospital and the University of Toronto. I did spend 29 years in the Canadian armed forces and retired about a year or so ago. At that time I pursued a career in hospital pharmacy again and I started working at the Riverside Hospital as the drug information pharmacist.

Not only have I worked in military and civilian hospitals but I have continued to work as a retail pharmacist, assisting in part-time help where oftentimes pharmacists have difficulty getting away for holidays and have problems on weekends. I've worked in a number of pharmacies in the retail area that are smoke-free, and at present I am working in two local pharmacies in addition to my affiliation at the Riverside Hospital.

The points that I wish to leave with you are highlighted there, and I certainly fully support the passage of Bill 119 and heartily endorse the proposed removal of tobacco products from pharmacies. I also feel strongly that the introduction of plain packaging would have a significant impact on reducing the quantity of tobacco sold. I also recommend that retailer licensing for tobacco products be mandatory and that effective enforcement be instituted to deter the sale of tobacco to minors.

As a pharmacist working in a community hospital with a palliative care unit, I frequently see the end results of people who have used tobacco for many years. Often they commenced smoking when they were at a very young, early age, usually in their teenage years, and it certainly leaves an impression. One does not go to sleep too easily that night if you've seen a person gasping for his last breath.

When one considers the premature deaths that are often the result, and at significant costs to society, it behooves us as pharmacists to carefully consider our image and the role as members of the health care team with regards to the tobacco issue.

I am somewhat saddened by some of my colleagues who have appeared before this committee claiming that they are dependent on the sale of tobacco to maintain a viable pharmacy operation. The doom and gloom about reduced pharmacy hours, cutbacks in services, layoffs and pharmacies going out of business I feel is premature.

I do not believe that pharmacy needs tobacco sales to maintain profitability. As I say, I've personally worked in several tobacco-free pharmacies that are still in business and in fact have attracted many new customers because of their position held regarding the tobacco issue.

Throughout the years I have devoted my efforts to

providing drug information and advice to patients on health care matters as well as dispensing prescribed medications. On moral, ethical and professional grounds pharmacists must now decide if they wish to continue to be viewed by society as responsible members of the health care team.

I firmly believe that the vast majority of pharmacists support Bill 119 and that they do not want to be seen by the public as professionals who dispense lifesaving drugs at the rear of the store but then sell for profit a product demonstrated to be detrimental to the public's health at the cash register.

During two tours of duty in Germany as a military pharmacist I could not help but be impressed by the professional image displayed by pharmacists in this country and the high esteem given to them by the German people. Pharmacies in Germany do not sell tobacco products and their product lines are carefully selected to support the professional image of the pharmacist.

I firmly believe that the time to deal with the tobacco problem is now. I strongly urge you to support Bill 119 and strengthen the impact of this bill on controlling the availability and distribution of tobacco. Clearly the uncontrolled use of tobacco is not compatible with a healthy generation in the future.

Just as an aside, February 14 is always a special day in my life, not just because of the traditional thoughts which come to the surface, but I have three grandchildren under the age of 10 who celebrate their birthdays on Valentine's Day.

**Mrs Haslam:** Easy to remember.

**Mr Jones:** Very easy; it makes it very simple. It would sure be wonderful if my grandchildren are not exposed in the future to secondhand tobacco smoke and do not have to face the social and peer pressures that our teenagers have to face today.

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**Mr Tony Martin (Sault Ste Marie):** I find your presentation to be very concise and to the point. We find at the moment, given what's happening out there re the decision of the federal government to back away from taxes and all that, that's quite a challenge, to say the least, and we feel very strongly that it will impact very clearly on government's attempts to stem the use of tobacco in the country.

Given that we have folks who would disagree with us on the piece that you spoke to today re the selling of drugs in pharmacies, I guess maybe making it a bigger issue than the inconsistency that's there and the double message that's there in selling tobacco products in the same place as health promotion, our sincere desire is to really make this a piece of legislation that will be effective. In light of all of that you talk about licensing, and I think that has some potential and we need to look at it certainly more closely as we try to figure out what to do at this point in time.

We have some ideas in the bill around an increase in fines for stores that would sell to minors and we propose to do that. Have you looked at that, and is there anything

we could do with that as opposed to the licensing? If we get into the licensing, I'm sure the small corner stores and businesses will not be really happy with us. They're already complaining about the overregulation of business. We certainly don't want, if we can get away with it at all, to get in the way of people doing business in this province but we certainly want to wrestle this problem to the ground.

**Mr Jones:** I do have the feeling that one is going to have to look very carefully at the distribution sources, and this is one of the concerns that I think has been demonstrated, that now our young children or teenagers have access to and can get a hold of cigarettes. There don't seem to be enough teeth to really discourage people from selling cigarettes to underage children, and the licensing issue may be one way. It has been, I think, mentioned that the licensing fees would help perhaps to offset some of the costs of policing this, but it certainly is not an easy problem. I don't have any panacea to offer you in terms of handling this, but it will be a concern, there's no question.

**Mr Martin:** I found the previous presentation quite interesting. It was different than most of what we've heard so far, the challenge that is presented by all the things that she spoke about. Do you have any comment on that?

**Mr Jones:** Again, I'm coming from a totally different point of view. I'm not in the retail business as such and I feel very strongly that pharmacists, if they're going to maintain a professional image, have to break away from the image that they are mass retailers and that they may have to take a look very carefully at what happens in many other countries where pharmacy is truly much more closely related to physicians, to the hospitals, and they're not mass retailers.

You don't find garbage pails and tires and batteries in drugstores in Switzerland, Germany and France. They don't have this sort of thing. I think we've gotten into a bit of a trap in that our pharmacies in North America have become pharmacies with a very small pharmacy and they've been mass merchandisers. This perhaps is a very big mistake.

**Mrs O'Neill:** Mr Jones, thank you for making the correction about Riverside Hospital. I'm very happy that you likely had the same opportunity as I to work with Brian Doyle, your former CEO, who has been a great loss to our community.

You come from a very different perspective than most people who have presented to us and you've certainly had worldwide experience. You could have chosen a lot of things to say and you did choose plain packaging and licensing. I wonder why you feel so strongly about plain packaging and why you feel it would help this bill and strengthen Bill 119.

**Mr Jones:** I think there's a certain aura that seems to be in the advertising world. I'm sure that when companies decide on how they're going to merchandise their product they certainly look at the packaging as a very major point to attract and to sort of make it macho to have that particular brand.

I think the plain packaging could probably serve two or three purposes. It may probably assist in some of the smuggling problems. It would certainly be less attractive to the younger people who often say, "I like the black package because that makes me feel great and I'm one of the in group." So that's my feeling there. Also, I would think this just makes good sense.

**Mr Sterling:** Thanks for coming to us and giving your submission. You mentioned three things in your brief in terms of what you would like to say to us. One, as my colleague has just mentioned, is licensing, the other is packaging and the third is the sale of cigarettes from pharmacies.

I hate the results of tobacco in terms of the health of our people. Therefore I as a legislator am looking for things to do and I'm quite willing to regulate, even though my general nature is not to regulate as a Conservative. Of those three, would you rank for me what you think would do the most and what would do the second most and what would do the third most to stop the use of tobacco in our province?

**Mr Jones:** I would say certainly you can mix and match the order that they're in. The bill definitely has a point that has been very controversial, and that is the pharmacy issue. I feel quite strongly that the sale of tobacco in pharmacies should be removed. This may not impact on the total utilization. I would have to agree on that. Cigarettes are still going to be available. I think that from the impact of using, perhaps your more effective licensing of people who sell, and then followed by the introduction of a method to change the package into a common type of package.

**Mr Sterling:** So you would put third the sale of cigarettes from pharmacies in terms of consumption?

**Mr Jones:** Yes, in terms of consumption. I think I'd have to have my head in the sand if I thought that just taking tobacco out of pharmacies would decrease the sale. That's not realistic.

**The Chair:** Thank you very much for taking the time to come down to the committee this evening. We appreciate it.

RAJ GANDHI

**Mr Raj Gandhi:** Good evening, Mr Chairman and members of the standing committee. I haven't prepared a submission for you to look at because I'd like to just speak generally about some points that I feel strongly about with regard to this bill.

My name is Raj Gandhi and I'm the owner of two community pharmacies in Ottawa. Both pharmacies do not sell tobacco. Tonight I would like to speak in support of Bill 119, and specifically the part that proposes to ban tobacco in pharmacies.

I believe that tobacco products are no longer compatible with pharmacy. It is a conflict of interest and hypocritical for pharmacists to dispense prescriptions in the back and sell tobacco in the front.

Some pharmacists will tell you that this is an example of government interfering with business. Nonsense. The part about banning tobacco in pharmacies was initiated by the Ontario College of Pharmacists.



There is no question that some pharmacies will suffer financial setbacks. However, this will be offset by lower insurance and inventory cost and reduced break-ins. A recent Ottawa Citizen editorial quoted that 76 out of 133 pharmacies voluntarily stopped selling tobacco. If they can survive, why can't the other 57 pharmacies?

It's time to have a level playing field for all pharmacies. Do I think there will be a loss of jobs if this bill is passed? Possibly a few. Will pharmacies close up left, right and centre? Definitely not.

For pharmacists who tell you that they are in the best position to sell tobacco because they can counsel patients on how to quit, that's hogwash. Pharmacists don't have the time or they don't have the physical layout to be able to do that on a regular basis. Most stores are quite big and the pharmacist does not even see who is buying tobacco at any given time.

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I would also like to recommend that if the bill is passed with regard to banning tobacco in pharmacies, it should be clear enough and it should ensure that as far as pharmacies are concerned, the law is fully enforceable and enforced and not tied up with injunctions and extensions; also that some pharmacies do not circumvent the law by altering their stores. Supermarkets and department stores with pharmacies would have to choose whether they would want a pharmacy in their store or to sell tobacco.

It's time to send a clear message to the citizens of Ontario, and especially the teenagers, that tobacco products are highly addictive and pharmacists will only be entrusted in helping you quit, not helping you get hooked.

I applaud Ruth Grier and the NDP for trying to pass this very tough legislation and I hope they don't buckle under the pressure from the powerful tobacco companies. I thank you for allowing me to make this presentation.

**Mr Eddy:** Thank you for your presentation. As you gather, this is a very controversial subject. You've heard about the pharmacies in the very large stores. Zellers has been mentioned; Wal-Mart coming in may be mentioned. Do you see a problem with controlling it where there's a very large store?

**Mr Gandhi:** This is why the legislation has to be clear, if Zellers or Loblaws or Wal-Mart or K mart wants to have a pharmacy in their store.

**Mr Eddy:** Then you would see the same rule apply, no matter how large it was, as to a small pharmacy?

**Mr Gandhi:** Absolutely.

**Mr O'Connor:** We've had the opportunity to hear from a huge number of pharmacists on two sides of the issue, and pharmacy students as well. The pharmacy students I think were really torn because as they went through their schooling they thought, as they were coming out of it, that they were going to go out and become health care professionals and they didn't see themselves as walking into this type of conflict.

I'm sure for those who have sat back and listened to the hearings with a great deal of interest because of course this is their chosen profession, for those who have

been torn by listening to those who are arguing, "We're retailers and we're not really health care professionals," and those like yourself who I can see take a genuine interest in the health care element of pharmacy that these students are studying, you show them an example of what you can do and you can actually fulfil what they go to school for. I thank you for your presentation.

**The Chair:** Mr Gandhi, thank you very much for coming before the committee this evening.

HEART AND STROKE FOUNDATION OF ONTARIO.  
OTTAWA-CARLETON REGION

**Ms Elinor Wilson:** It's a pleasure to be here in front of the committee tonight to present on behalf of the Ottawa-Carleton region of the Heart and Stroke Foundation of Ontario, representing over 3,500 volunteers in this area. It's also particularly appropriate to be here during Heart Month since the issue that you are dealing with is a very significant issue as it affects heart disease, morbidity and mortality in this province.

As mentioned, I have with me tonight James Howith, who is a student at Glebe Collegiate, and he was kind enough to come this evening to reflect on some of his experiences with tobacco. After James has spoken, I will try to do a very brief summary of some of the major points in our heart and stroke foundation submission. James, I'll turn it over to you.

**Mr James Howith:** Thank you very much. Like Ms Wilson said, I've just been asked to represent a youth perspective from tobacco and the effects that it has on youth in our society.

I'm 19 years old and I am a Glebe Collegiate student. I started smoking when I was 14 years old and influences on my life were quite numerous. The media definitely portray a very strong influence on youth to portray a very glamorous image, and that certainly had its effect on me, and peer pressure as well. For the most part, what made it so easy for me to smoke was just the sheer accessibility for me to get cigarettes. I don't know how many of you noticed that smoking typically affects your growth. It hasn't for me.

**Mr Sterling:** I never smoked.

**Mrs Haslam:** We don't believe you.

**The Chair:** Order.

**Mr Howith:** It was quite easy for me to obtain cigarettes. The hardest part for me would be the sheer cost. I was quite financially unstable growing up, so money was somewhat scarce for me to support my habit, and also being a minor and not having a job.

In short, I am personally in support of Bill 119 because of the fact of how it puts limitations and constraints on age and accessibility to youth and to minors. On another personal note, I agree with the previous speakers, Mr Georgewill and Ms Burpee, just because of the fact that the image a pharmacy or a drugstore portrays is that of a health care profession and I feel it directly negates or contradicts the message it's trying to portray.

Briefly, in summary, as I said, I smoked for four years. It was easy enough for me to get them; I didn't have a problem. That could be because of my physical appearance. I quit a few times. Last time I quit was last year,

and fortunately it has stayed. I had to quit cold turkey because methods of quitting are quite costly, regardless of what they are. The patch—I don't know what that's running at, but that was beyond my financial abilities. That's just it.

My personal feelings on smoking are that it's disgusting, it's gross, it has negative health factors involved. I'll shut up. That's it.

**Ms Elinor Wilson:** I think the issue in terms of tobacco control is the issue of comprehensiveness. I'm sure, as you've heard many submissions and as you've questioned many presenters, it's relatively easy to define parts of this issue and to ask specific questions about parts. I think what I'd like to try to do is to put these parts back together tonight and talk a little bit about the comprehensive package that needs to be in place to control tobacco, not only in Ontario but Canada-wide.

I think you're probably aware that Canada has led the world in the control of tobacco. In fact we as a country are a model for many other countries that are planning their programs and their approaches based on the leadership that has been shown by Canada. This was not done in a piecemeal fashion. The combination of education, legislation and taxation, all working in a synergistic and multiplicative fashion, have made us the world leaders that we are in tobacco control.

I think with the current rollback in the federal taxes it behooves us to now look even more at the comprehensiveness of the package of measures that you are bringing forward in this province. Unfortunately, whether we like it or not, I think Ontario is going to have to increase and even strengthen the measures that it is proposing in order to offset in any way possible the impact that this tax rollback will have.

I think if our major issue here is to prevent children from accessing and from using tobacco products, there are three particular areas where we could look at that not only should we bring into being but perhaps even increase from what we see in the proposed bill.

The first one is the whole issue of statutory prohibition. As you will see from our brief, the Heart and Stroke Foundation of Ontario has supported in principle the idea of statutory prohibition, provided we can be sure that adequate enforcement will take place. The question now, with the reduction in prices, is how much more of an impact that will make on numbers of people buying cigarettes and the ability of people to actually enforce this statutory prohibition.

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We would like the committee to take into account the issues of licensing and, as you go into your in-committee deliberations, to please look very carefully at our ability in this province to enforce statutory prohibition to prevent children from accessing tobacco products.

The second thing is the restrictions in terms of smoking in public places and the exposure to secondhand smoke. With that I will sort of throw in workplaces, because if I look at the young people of today and people like James, a lot of the jobs that they have in order to support themselves are in places such as restaurants and

bars, where they are exposed in their workplace to secondhand smoke. We're not just talking about workplaces that only employ adults. We're talking about workplaces that do employ the youth of today. Given that cigarettes will now be easier to access, one of our other measures is to now decrease as much as possible the places where we are allowed to smoke cigarettes.

Last but not least is the issue of plain packaging. You've heard James talk about the allure of plain packaging. That's all tied up in the whole advertising issue. Despite the fact that we do have an advertising ban in this country, there is a report I will leave with the committee on a study done about tobacco sponsorship advertising, specifically in the Ottawa region.

It was released by the Canadian Council on Smoking and Health during National Non-Smoking Week and it really very clearly pointed out that, despite the fact that we have a supposed ban on advertising, we are still inundated on a daily basis. In fact in this region every adult is exposed to a minimum of two messages a day, be that at point of purchase or in a bus shelter, to advertisements for a product that kills when used exactly as intended by the manufacturer.

If we are looking at this whole issue of plain packaging and allure, I think that our plain packaging would help to break the link in people's minds between the package colours, their design, their graphic layout and what we see in these point-of-sale advertisements, what we see on billboards sponsoring sports and cultural events. It's not until we can do all of these things in a comprehensive fashion that we are going to be able to protect the youth of tomorrow from some of the ravages that we are seeing in our adult population.

Once again, I thank the committee for the opportunity of presenting and commend the government, the Minister of Health and all parties for being as rapid as they have been in bringing this forward. I hope that you have a sense now of real urgency, given some of the national issues, and that you will look even more diligently at this bill. Thank you.

**Mr Jim Wilson:** Thank you for taking the time out to appear before us this evening. I think you're right that perhaps with the unfortunate consequences of the lowering of the tobacco taxes, the upside to that may be that, with this bill before the Legislature, it's an opportunity to do even more than what legislators might have otherwise been inclined to do. We don't want to miss that opportunity because we want to try and discourage young people from starting to smoke, which is the objective of the bill.

James, I just want to ask you a question, because we've had other young people who were smokers appear before us and say that it really doesn't matter what you do, "Oh, whoopee ding dong, you're raising the age by one year, you're taking it out of pharmacies, but we'll get cigarettes anyway." They really, I think, hit home the fact that this is a very difficult problem.

One of the things we've been kicking around is the idea that what this bill does is really continue the old model, and that is that we put all the responsibility on retailers. I mean, Becker's store or any other store that



sells to someone under the age of 19 after this legislation passes is going to get nailed pretty badly. That's not much different than the current law, which is 18. Young people tell us that doesn't really work because they just keep trying retailers until somebody sells it to them.

We're wondering about whether we shouldn't be putting some responsibility on young people themselves. There is a model in the States where it's not a criminal offence but is treated somewhat like alcohol in terms of fining young people under a certain age. In one model in the United States they have a licensing system for retailers, but they also have a \$25 fine for young people who are in possession of cigarettes or who are caught smoking under a certain age.

In your struggles, which you were very honest about, given that you said you didn't have a lot of money when you were growing up, would that have in any way made you think twice about smoking under a certain age?

**Mr Howith:** Personally, it would certainly have a deterrent effect. It would make me think twice, but it would also make me be that much more careful. Like, 25 bucks is 25 bucks, regardless of who it is, in these hard economic times. But I see some serious fault in enforcing a proposition like that. Are you going to have smoking police running around checking for ID? That doesn't sound too realistic to me.

Certainly it is a personal choice for someone who wants to take up the habit, and it's an unfair battle for youth nowadays, in my opinion, because of the image that's being represented of smoking. You see these Marlboro men in the big, white cowboy hats. They're very masculine-looking figures, and young males would want to look up to and want to be that type of person, because they figure they'd gain popularity. That is essentially the mentality behind the young people today who are facing this issue.

I believe the only way to take steps against the increasing number of young people smoking would be to portray this differently within the media, have a different effect on the exposure rather than just the enforcement.

**Mrs Haslam:** On page 7 you talk about annual reports on "the effectiveness of statutory prohibition," which is what is in the legislation, and I commend you for knowing what's in the legislation. We've seen people come forward and say, "We want it to be licensing."

Our concern is, can we put it in place without a bureaucracy, can we put it in place without a large outlay of money when that money can go into enforcement, which is where all of us feel that the best efforts are? I think you agree that enforcement is really where we should—you're going to have to say yes. The Hansard doesn't record nods, for some reason.

But having said that, I wondered what time lines you were looking at. I know you're recommending annual reports on the effectiveness, but I wondered how long you would consider annual reports because then you said, "If it proves to be ineffective and unenforceable, it is recommended that a retailer licensing system be implemented." In what time lines are you looking at that?

**Ms Elinor Wilson:** It would seem to me that you

would need a time line to ensure that all retailers were adequately informed of the law and of the penalties around the law. I would say that should not take more than a year to reach retailers. In fact there have been many examples of how retailers have already been reached by other methods and by the tobacco industry to post signs. I'm not sure that there are a lot of retailers who are unaware of the law.

I would say that, at a minimum, you're looking at a yearly report from your chief medical officer of health. To me, I would expect in year 1 to be seeing adequate enforcement and we weren't seeing a sudden, very sharp increase. I recognize that will be difficult to deal with if Ontario is forced to roll back taxes, because I'm afraid the health community is expecting to see something that we will not like to see. It will be hard separating out those two things. But, on the other hand, an increase is an increase, due to whatever means, and if we can't start to see that this is being kept under control, then we would need to look very seriously at the issue of licensing.

**Mr McGuinty:** I want to start with a comment. You raised an important problem, and that is this issue of enforcement. A number of other presenters have raised that as well. I think we simply do not have the financial capability, the personnel to enforce this kind of law. That's not the end of it, though, and that's not necessarily the overriding factor in this.

You know, when it came to drinking and driving, the components that went into deterring that, I think there were three important ones. One is we bumped up the severity of the penalties. Second, we had these spot checks, the RIDE programs and, third, and I think very important, it became socially unacceptable to leave that house drunk after drinking.

I think that we don't have the personnel, as I say, or the money to police 120,000 stores in this province. If they each only sold one pack a day, that's 120,000 transactions. They must be selling many more than that, so you can just think of how that'll increase exponentially. I think at the end of the day it just has to become socially unacceptable.

James, I want to inquire a little bit more about the patch. You couldn't obtain the patch?

**Mr Howith:** No. Just due to financial constraints.

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**Mr McGuinty:** That's not covered by OHIP?

**Mr Howith:** Not that I believe.

**Mr McGuinty:** Okay. I wonder if that's something that maybe we should be looking at. From a government perspective, if we were to prescribe one series of patches, if that's how it works, I think we could save the taxpayer a lot of money in the long run if we get somebody hooked from cigarettes.

**Mr Howith:** I appreciate that point. Me being the cynic that I am—

**Mr McGuinty:** But it's too late?

**Mr Howith:** That's a good point as well. Me being a cynic I don't believe, like I said, in these hard times of bouncing back from a recession, that people are going to

want to reap long-term goals due to other people smoking and trying to get them to quit. I believe in the long-term goals and the benefits but I just don't think that right now at this point that would be entirely feasible, like I said.

**Ms Elinor Wilson:** I just wanted to go back to the issue of social acceptability. I think you would agree that we have seen a dramatic change in social acceptability over the years, and I think one of the things that creates social unacceptability is the fact that you can't do the behaviour in very many places, you can't find the product with which to do the behaviour, so I think all of the measures that we're talking about here are going to help to increase that social unacceptability.

The flip side of that is, though, I think we must be very cautious not to turn this into a "Let's blame the smoker" and paint the smoker as the bad person in this. This is not an issue about smokers versus non-smokers. This is an issue about tobacco control and it's about non-smokers and in fact most of society fighting to control a lethal product. Most of our surveys that we have show that smokers and non-smokers alike are very supportive of restrictions around access for young people, so it doesn't make a difference whether you're a smoker or a non-smoker.

I think we need to be very careful because we're dealing with a clientele that is addicted. They're to be assisted and helped, not frowned upon for being people who just do this and you'd think they would just quit.

**Mr O'Connor:** I only have a couple of points I'd like to share with the committee members. The price of the patch is around the same price as what it costs your average smoker for a pack a day, so it's in that balance. Some may have some problems with that, but it's making up your mind that you're going to try to tackle this addiction and many other parts of it.

The other thing is that it's not recommended for young people just because of the toxicity of that patch. It's not recommended for teenagers, for example, who might be in high school who got addicted in grade school. It's not recommended for that group because it's so toxic. That's why of course too it's something that's regulated with the pharmacist and requires a prescription. Thank you.

**The Chair:** I want to thank you both for coming and appearing before us this evening.

PHYSICIANS FOR A SMOKE-FREE CANADA,  
OTTAWA REGION

**The Chair:** If I could then call on James Walker. Mr Walker, just to be clear, I take it you are in fact a medical doctor?

**Dr James Walker:** Yes.

**The Chair:** You are here representing the Ottawa branch of the Physicians for a Smoke-Free Canada?

**Dr Walker:** That is right, and I'm here with Cathy Rudick, our executive director. I'll be making the presentation but she may provide some backup information.

I would like first to congratulate the government for bringing forth the bill and in fact the all-party support that this bill has received. We feel it's a very significant piece of legislation in terms of preventive health care in this province. As physicians we are particularly delighted

to see the stand on the sale and use of tobacco in health care facilities, and in particular we are pleased to see the stand taken on the ban of the sale of tobacco in pharmacies.

I'd like to give you a bit of history as to what has happened in Ottawa with our organization and with the pharmacy issue. In June 1989 we initiated what was then a pilot project to promote those pharmacies in Ottawa-Carleton that did not sell tobacco products. It was never a boycott; it was always a promotion campaign. At that time, when we started out, there were only 28 pharmacies of 129 in the area that did not sell tobacco.

Within two months of starting our campaign there were 11 more; the number had increased to 39 and a year and a half later it was up to 51. In our last full campaign we actually went to the drugstores to check them last August. If you refer to page 8 in your handout, table 1 at the top of the page, these are the August 1993 study results, and if you look at the column "Do Not Sell Tobacco" you'll see that the total in August was up to 70 out of 127 pharmacies.

What's more revealing, however, is when you look at who sells tobacco and who doesn't, and that is 75% of independently owned pharmacies do not sell tobacco in their pharmacy. In the 20 Shoppers Drug Marts they all sell tobacco and one Pharma Plus does not sell tobacco.

If you look further into our report you will see that the next four tables represent the recommendations of the Ontario College of Pharmacists and the compliance and violation of different pharmacies in their setting, whether they're independent or chain stores, with those recommendations. You can see that the compliance with the recommendations of the Ontario College of Pharmacists is far and away greater by independents and that the chain stores are the main problem in terms of compliance with their own governing body.

There are four points that I would like to make as a result of our studies.

First, it is very clear—you can see from table 1—that voluntary regulations do not work, that we need legislation to control this issue.

Second, of all the pharmacies that have stopped selling tobacco we have had none of them go out of business, and we are unaware of any pharmacy in the country that has stopped selling tobacco that has gone out of business. We would challenge the tobacco industry and bodies that represent the tobacco industry indirectly to bring forth a pharmacy that has shut down as a result of stopping tobacco sales.

Third, there's a very inherent conflict of interest. If you sell tobacco in a pharmacy and you're also selling health-enhancing medications, including those used to treat tobacco sickness, that to me and to our organization is a very grave conflict of interest.

I would make a comparison. We have a number of members who are respirologists who are chest physicians. They make their living basically treating people with chest disease. Can you imagine if they had tobacco vending machines in their waiting rooms? That would be totally ludicrous and in fact they would lose their licence



under the College of Physicians and Surgeons.

Fourth is the mixed message, particularly to youth who walk through an arcade of tobacco products. As you can see from the compliance with the recommendations, in many stores, particularly the large chains, there still are arcades of tobacco products at the entrance of the stores. If you go to the back to fill your prescription, health-enhancing medication, and you walk back through that arcade of tobacco again, what message does that give to our youth, because our youth are the potential future of the tobacco industry?

We will be submitting further data on eight other Ontario centres and their compliance or non-compliance with the recommendations of the Ontario College of Pharmacists, and these will be submitted later this week or early next week to this committee.

Other aspects of the bill that we're very pleased with are the vending machine laws. We think this is very progressive and something we've been working on for many years.

With the aboriginal issue, we would like the ceremonial and religious terms to be defined as to what is ceremonial or traditional religious use of tobacco. We are concerned that native youth may be unnecessarily exposed to tobacco in what is considered a gift. I have difficulty understanding, although I appreciate I don't have an aboriginal background, that a gift of tobacco would be a good gift with what is known now.

We also have some concern on the aboriginal clause about exposure to environmental tobacco smoke of non-aboriginal people in a health care setting in particular. We would like those areas to be more clearly defined.

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Despite the recent announcement federally that there will be a minimum pack size of 20, we ask you to keep that in the bill simply because at this point in time we have considerable distrust and concern for the federal approach to tobacco in this country.

We would also like to put forth a major amendment, which is included on page 5 in your handout, and that is to bring plain packaging into Ontario. Ontario has a chance to be truly a world leader as well as the Canadian leader on this issue. The serious effects of the recent federal tax rollback make this more urgent than ever, particularly with the increased consumption that will result particularly among our youth and with the decreased revenue.

Obviously we are all aware that Ontario is in the position within the next few days that it may, and it sounds like it will, have to fall down in the domino effect that's going to go across the country with tobacco tax rollbacks. We need to counteract this.

The major benefits of plain packaging are, first of all, the removal of the allure of carrying that pack with the trademarks and the associations with those trademarks and colours; second is that the health warnings will be much more prominent when they're on a plain package, and probably one of the major things is to break the connection or the link to tobacco sponsorship.

As you know, as a result of the Tobacco Products

Control Act, the federal act, tobacco sponsorship has increased to the point that it's their major form of advertising. But that advertising has to be linked to a package, to something that the child buying tobacco can identify with. If it's in a plain package, then it will really weaken that major form of tobacco advertising that is now under the guise of sport sponsorship or sponsorship of the performing arts.

We feel this issue of plain packaging is of the greatest urgency, and if it cannot be an amendment to Bill 119, we would suggest that it be put through very rapidly as a separate bill. Also, if Ontario can hold up on the tax rollback, it has a chance to identify those packs which come into Ontario from other provinces because the plain package would be Ontario's tobacco.

In concluding, I'd like to go back to the basics: What is tobacco? It's a compound that has no innate value other than to maintain the addiction it creates and it is the only consumer product that we are aware of that is both addictive and lethal when used as intended.

The pharmacist who puts tobacco sales before the personal wellbeing of his or her clientele can hardly be considered a health care professional. We would also predict that if tobacco is taken out of pharmacies, considerable funds from the pharmaceutical industry will become available to be used for health promotion in the field of tobacco prevention.

In 1989, when we initiated this campaign, we were receiving pharmaceutical funding. Because we would not back down on this campaign, we lost all that funding and we have good reason to believe that this was due to pressure from the tobacco industry directly.

We would also like to challenge particularly the Liberal members of this committee to confront their federal counterparts, your federal counterparts, in terms of the mismanagement, as far as we're concerned, of the federal tax rollback and to push for stronger federal anti-tobacco legislation as soon as possible.

Bill 119 must not be weakened by tradeoffs with the tobacco industry. There's no room for compromise with an industry that addicts children and sickens adults. Remember, Shoppers Drug Mart is part of that industry.

Physicians for a Smoke-Free Canada recommends that Bill 119 is strengthened by the amendment to immediately introduce generic packaging. Thank you.

**The Chair:** Thank you very much, Dr Walker, and again I just note for the record that you have left us with a very full submission with a lot of other data from your study and from the work that you've done here in this area. We just want to thank you for all of that as well.

**Mr Jim Wilson:** Thank you, Dr Walker, for the presentation. I think it's unfortunate that really the only controversy in the bill has been the pharmacy issue. Mr Sterling earlier today pointed out that is indeed unfortunate because it's perhaps taking us away from strengthening the act and the true goal of the act and, I think, from the public understanding the act.

I've said many times during this hearing—and you may have inadvertently fallen into this today when you said that the government should keep the ban on kiddie

packs in the bill. Well, it's not in the bill, neither is plain packaging, neither is ETS, neither is workplace, and you know that.

But I've read newspaper articles and people tell me this is the greatest bill in the world because it contains all that. The government is asking for the regulatory authority to do some of this stuff, but the bill itself is extremely weak and I think that because we focused so much on the pharmacy fight, I don't know why health groups aren't coming here and screaming at the government and saying, "We want to know what your regulations are now because this bill is hollow without some meat on the bones." Do you have any comments on that?

**Dr Walker:** Yes, I do. I don't agree that the bill is hollow. I think there are some very significant things that are in the bill per se. To watch the pharmacy issue and the health care issue is extremely significant in terms of the role model for society that it gives. If we were to write the bill, we would write a much stronger bill, very definitely. We would deal with an awful lot of issues. We don't write the bill.

With regard to the issue of plain packaging, I realize it's not in the bill and that's why we've put it forth as an amendment to the bill. We've been through this with the Canadian Tobacco Products Control Act and the Non-smokers' Health Act. Regulations are just fraught with problems. We feel the main issue should be in the bill. In particular, plain packaging I don't think can ever be underestimated as to the impact this will have.

I appreciate the other things you say are not in the bill per se, and we have concerns about the regulations, but there is certainly a lot of strength in this bill.

**Mr Jim Wilson:** If we see the regulations is my point, but I do appreciate your comments, because you're right.

**Mr McGuinty:** Thank you very much for your presentation. First of all, you're to be commended for bringing about a reduction in the availability of tobacco products in our local pharmacies here.

Second, I think you make a very, very good point. Something that's coming to rest in my mind over the days is that one of the most substantive improvements we could bring to the bill was to address this issue of plain packaging.

I've developed an understanding now that, for kids, a package is an accessory akin to an article of clothing, earrings, a belt, the latest style of shoe, something that you want to be seen with. Have you actually prepared an amendment? Has somebody actually prepared an amendment that we could use?

**Dr Walker:** I don't know how prepared you want it. In our statement on page 5, we have our statement about amendments.

**Mr McGuinty:** Right.

**Dr Walker:** Also in the appendices, I believe it's appendix 1, is the detail on what plain packaging is.

**Mr McGuinty:** Yes, I found it very helpful.

**Dr Walker:** If you want us to write an amendment, we'll have you one in no time.

**Mr McGuinty:** I'd appreciate that. I guess the other thing I wanted to ask you was—actually, I've lost my train of thought now, you've been so helpful.

**The Chair:** Shall I go to another train?

**Mr McGuinty:** No, I know what it was. This issue of the packaging, I gather that the federal legislation was the subject of a court hearing at the primary level in the Quebec courts and then it was appealed. It was upheld at the appeal level and now it has gone to the Supreme Court of Canada and a decision is to come down in April of this year, as I understand it, for that.

**Dr Walker:** That applies to the Tobacco Products Control Act?

**Mr McGuinty:** Right. I gather a packaging provision would likely be the subject of a court action. Does that make sense? I'm just thinking that tobacco producers would be up in arms over this. I'm just trying to anticipate, so that if we do something, we'll know what—

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**Dr Walker:** One thing we've learned in the anti-tobacco campaign is the more noise you get, you know you're on the right track. I guarantee you're going to get a lot of flak and, yes, there probably is going to be a legal challenge, but that shouldn't make us back down, because that means it's an effective move. To me and to our organization, and I think I can speak for many health care organizations, plain packaging would be a very, very big step in the right direction. To make a big step you're going to have to take the flak and deal with it appropriately.

**Mr McGuinty:** Thank you.

**The Chair:** To another train of thought, then, and Mr Winninger.

**Mr Winninger:** Thank you for your presentation. Just two quick points: Your recommendation with regard to section 12 concerning the traditional use of tobacco by aboriginal people might be problematic in that—of course you're probably aware that tobacco is sacred and it's passed from generation of elders to the next generation.

But aside from that, in the context of our Statement of Political Relationship that the province entered into with the first nations on a government-to-government basis, the strategies around aboriginal healing are largely self-determined because of their self-government aspirations. So it may, in fact, be up to the aboriginal people themselves, in light of their traditions, to define what is ceremonial use and what is not, as opposed to non-native governments dictating what those definitions should be. That was one comment.

**Dr Walker:** I understand your point. On the other hand, I would think it is in the aboriginal people's best interests to clearly define what ceremonial is so that their youth are not inappropriately exposed to the misuse of tobacco.

**Mr Winninger:** I expect it will be.

Just one other brief point: I think your suggestion with regard to plain packaging is a good one, but you're undoubtedly aware that there is a federal legislative component to that as well because it involves packaging.



I was wondering what you and your organization would be prepared to do to apply similar pressure to the federal government so they could work with us towards that very worthy objective.

**Dr Walker:** We would certainly be glad to apply pressure to the federal government and in fact the anti-tobacco community has been doing that for some time. We see an opportunity in Ontario to be true leaders here.

Just like the smuggling issue and the tax rollbacks appear they are going to domino across our country from Quebec, I would say if we do this in Ontario, we're going to have the same positive domino effect with plain packaging, and Ontario can quite rightfully be a true leader if we put it in this bill at this time. I think to wait for the federal government to move on it would be a mistake. We will push them as well, but I encourage Ontario with the greatest of urgency to deal with plain packaging now.

**Mr Winner:** I wonder, just on that point, whether there is any clarification that might come from the parliamentary assistant or the ministry official as to what the federal limitations are on what you're suggesting.

**Mr O'Connor:** I appreciate the opportunity to shed a little bit of light on this. I've got no doubt in my mind as we sit around here and discuss this important issue that it would no doubt end up in the courts with a challenge. The provincial governments right across this country, the Health ministers, hoped that the federal government would move on the plain packaging issue because there will be a challenge.

We would just as soon, instead of having to fight this battle in Ontario and then fight this battle—well, it may not be in Quebec because they don't think this is a health issue—but all the other provinces across this country, we hope the federal government would take leadership in this issue, and that's why the Health ministers have tried to work with the federal government on this.

The Minister of Health sent a letter to the federal Minister of Health in January 1993 asking for that to take place and, of course, that government of the day didn't feel that it was an important health issue and didn't move on it. Mr Chrétien has thrown this out as a possibility.

We've put in the legislation the abilities for us to do this and we will definitely be looking into that. The difficulty we have is, we want to get this legislation introduced and back into the House for third reading so we can work on the balance of it, but it's not like we're going to forget about taking a look at that issue as well.

I appreciate what you said and I think the appendices you put on there are very concise and I think will help me in our discussion within the ministry.

**Dr Walker:** Again, we feel very strongly it should be front row and centre in the bill, not in the regulations, because of the delay of implementation and the difficulties with regulations. I think with all-party support this should not be difficult to put plain packaging through, and I say we're going to have to accept the heat. So what if they give us a court challenge? We're on the right track.

**The Chair:** Thank you both for coming before the

committee. I suspect we could continue to discuss these issues, but I'm afraid time means that we must move on to the next witness. Thank you both again for coming.

ALLERGY/ASTHMA INFORMATION ASSOCIATION,  
OTTAWA CHAPTER

**The Chair:** I call on Ms Lois King, representing the Ottawa chapter of the Allergy/Asthma Information Association.

**Ms Lois King:** Yes. I'm the local Ottawa activator. I understand you have already heard from Sue Daglish, who's our national executive director, so I'll just very briefly summarize our position and put a little personal spin on this.

Just before I start, I hope Mr McGuinty has told all of you to bring your skates and take part—

**The Chair:** He has.

**Ms King:** —clear your brain and go out to enjoy winter.

**The Chair:** In fact, I should note for the record that Mr McGuinty led a party over to the canal earlier today and he has promised personally to skate to Carleton University.

**Mrs Haslam:** Although he didn't say what day on the plane and, actually, we know we can rent them just across from the hotel.

**Ms King:** Yes, and the Beaver Tails are excellent.

**Mr Dadamo:** All right. We're used to skating on thin ice.

**The Chair:** It's probably a good thing Mr McGuinty didn't hear what it was he had promised. Sorry, we're getting to the end of a long day.

**Ms King:** No, I understand. I'm your last speaker this evening. I'd also like to assure Ms Haslam that I will not use the term "level playing field." I caught a little bit of the televised stuff around 6:30 this evening on the provincial channel, so I guess you were here hearing other people at the time.

I represent a group of mostly volunteers, mostly very committed people who are trying to help others and themselves deal with asthma and allergies, in particular respiratory and food allergies. We know that about one in six Canadians have some kind of respiratory allergic disease. It could be asthma, it could be what we call hay fever, it could be rhinitis caused by dust mites or various other allergens.

Our major concern surrounding the issue of tobacco is not the addiction problem so much as the effects that it has on our health and the health of our children who are probably also going to be allergic-type people susceptible to all of these allergic respiratory diseases.

As you are aware, when you have asthma or when you have a respiratory allergic disease, you have quite a lot of inflammation in your lung tissues, in your nose and throat, in the eyes sometimes, and tobacco smoke is one of the most powerful irritants which aggravates this inflammation. It's also a preventable irritant.

There's not much we can do about the fact that there are moulds in the air, if you're allergic to mould; there's not much we can do about the fact that there's dust in the

air, but we sure do feel we ought to be able not to have to breathe tobacco smoke when we know it's detrimental to our health and when we know that it can trigger the symptoms of asthma and seems to be one of the most potent triggers for childhood asthma to begin.

This is not to say that childhood asthma would not eventually develop, but something has to start it off. You really don't like to see very young children with asthma, and especially it just breaks your heart to see very young children whose parents are smokers and who just don't seem to be able to stop smoking, even though they know it's bad for their children's health.

Most of us do our very best to have our symptoms under control. We don't like to go around wheezing and coughing. We feel that what we have is well-controlled problems but a somewhat hidden disability. We don't get very much sympathy from the general public when we say, "Please don't smoke near me because it really makes me sick." It's, "Oh, well, you know, you're a bit of a fanatic."

## 2100

We know that in other areas of physical disability we are starting to turn around public opinion that physical disabilities need to be accommodated. Our particular physical disability is that we are extremely sensitive to this very powerful irritant and it's one that we don't really see any justification in having to be subjected to.

We're asking for protection from this problem in all those aspects of our lives that we can possibly manage, in particular in public places. We feel that we have a right to clean air. We feel that we have a right not to be subjected to this avoidable irritant and this substance that compromises our health.

We are a border city here, with Quebec just across one of several bridges. We are very aware of jurisdiction and problems with making regulations, having them stop at one boundary and therefore not be applicable in the next. We do think that provision for smoking in public places should be regulated as a province-wide issue and not left at the municipal level.

I will not use that nasty term, but let us just say that it is very difficult to argue with people whose businesses depend on the fact that at their bingo hall they can have smoking, whereas in Ottawa you can't have smoking in this establishment, but down the road in Gloucester you can. We feel the way to get rid of this nonsense is simply to have it be a provincial affair and not left up to the municipalities. We also feel that we are making it easier, if you make it provincial, for people to make those regulations, since you won't have this problem of adjoining jurisdictions.

One place that we feel we need more strength in our legislation is smoking in the workplace. I was interested to hear the comment that you're wondering why the health groups aren't jumping up and down and why we're just leaving it to the pharmacies to make their point. Figuratively speaking, I'm jumping up and down. Smoking in the workplace is an issue that keeps on coming back. You think you've got a smoke-free workplace and it turns out that actually what you've got is certain areas

of your workplace which are smoke-free, but then you have places where people can smoke.

Smoking lounges don't seem to be the answer. What happens is, first of all, people are unwilling to make them as well ventilated and as separate from the rest of the workplace as would be necessary to prevent tobacco smoke from spilling out.

The other thing we've been hearing about, and I'm sure you've heard from other of our members, is that people are finding that these lounges are becoming the places where meetings are held, whether formally or informally. If there's a little meeting going on in the smoking lounge and you are not willing to go in there because of your sensitivity to tobacco smoke, then of course you're going to miss out on that meeting or you're going to go in there and compromise your health. So we feel there is a need for more work on this one, smoking in the workplace.

We know that we have a problem just now with the taxes and with what's happening, this unsettled state of affairs. It's always been my contention that cost really is a deterrent. But I think if we can make smoking extremely inconvenient for people and socially unacceptable, we may be able in some way to offset the ground we're going to lose with what seems to be the inevitable feeling that we're going to have to cut the provincial taxes on cigarettes. I think we need to work very hard on strengthening the provisions around smoking in the workplace and environmental tobacco smoke.

I'd like to thank everybody who has worked hard. I know this is not an easy job, being an MPP or an MP. This is a very important bill for us and we really urge you, please don't back down on any of this and please consider some of the measures you've heard suggested to strengthen it either in this bill or in future amendments. Thank you.

**Mr O'Connor:** Thank you for coming here. I'm going to have to look at a little bit of Hansard, because I was out of the room for a wee bit. As we've said clearly right from the beginning of this process, when the chief medical officer of health pointed out clearly that we have a huge public health problem here with tobacco, legislation alone can't do it. We're trying to do our best and we've got a lot of support from all members of the Legislature on moving forward and trying to control the access to tobacco products by young people.

We realize there's an awful lot of work going on out in the community as well from folks like yourself and the Lung Association and people working on cessation programs. I think by having these hearings, we've actually been able to maybe penetrate a little bit deeper into the community. We've had some presentations from young people in schools, so I think we've made this a topical issue right in the schools as well.

I think this issue, which we know kills almost 40,000 Canadians a year, 13,000 Ontarians, needs to be talked about and it's a problem that needs to be dealt with. With everybody working together at it, I think we're actually going to see us work a little bit closer to that goal of a 50% reduction by the year 2000. Thank you for your presentation.



**Mr Sterling:** I'm really happy to see that you're raising the issue of smoking in public places and the workplace. I first introduced a bill in the Ontario Legislature in December 1985. I was eventually able to get the then Liberal government to come around in 1989 to bring in some form of workplace legislation. In my view, it's a very deficient bill, and I told them that at the time.

I had hoped the NDP government, which supported my stand at that time, would have brought it in now to really put some teeth in the workplace legislation on where they should have separately ventilated smoking rooms, if they're going to have any. That would ensure that workers would have the right to a smoke-free environment, which they don't have under the bill as it stands at the present time.

It's interesting that I also brought forward in December 1985, and subsequently on three different occasions, different kinds of private members' bills to cajole the government to do something on a province-wide basis dealing with controlling smoking in public places. The Liberal government wouldn't do anything. We're going to have something done here, and I view that as the most positive part of this whole bill.

I do wish this government would do something about strengthening provisions of controlling smoking in the workplace, because the present legislation is not satisfactory for a lot of people who are presently suffering from asthma and allergies. I thank you for putting the emphasis of your brief on those two issues.

**Ms King:** There are a lot of other issues in the bill that I personally have very strong feelings on, but this is the one that goes most to the heart of what I do with the Allergy/Asthma Information Association. I am also the mother of a very young child and I sure don't want her smoking.

**The Chair:** Thank you very much for coming before the committee this evening.

Members of the committee, that concludes our hearings for today. Can I just remind you that we begin tomorrow morning at 9 o'clock sharp—the emphasis is on “9 o'clock” and “sharp”—go through until noon and then pick up again at 1:30 and go through until approximately 3 or 3:30 tomorrow afternoon. With that, the committee stands adjourned until 9 o'clock tomorrow morning.

The committee adjourned at 2110.





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## STANDING COMMITTEE ON SOCIAL DEVELOPMENT

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- \*Wilson, Jim (Simcoe West/-Ouest PC)
- \*In attendance / présents*

### **Substitutions present / Membres remplaçants présents:**

Dadamo, George (Windsor-Sandwich ND) for Ms Carter  
 Haslam, Karen (Perth ND) for Mr Hope  
 Winninger, David (London South/-Sud ND) for Mr Owens

### **Also taking part / Autres participants et participantes:**

O'Connor, Larry, parliamentary assistant to Minister of Health  
 Sterling, Norman W. (Carleton PC)  
 Villeneuve, Noble (S-D-G & East Grenville/S-D-G & Grenville-Est PC)

**Clerk / Greffier:** Arnott, Doug

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## Assemblée législative de l'Ontario

Troisième session, 35<sup>e</sup> législature

# Official Report of Debates (Hansard)

Thursday 17 February 1994

# Journal des débats (Hansard)

Jeudi 17 février 1994

## Standing committee on social development

Tobacco Control Act, 1993

## Comité permanent des affaires sociales

Loi de 1993 sur la réglementation  
de l'usage du tabac

Chair: Charles Beer  
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## STANDING COMMITTEE ON SOCIAL DEVELOPMENT

Thursday 17 February 1994

The committee met at 0900 in the Westin Hotel, Ottawa.

## TOBACCO CONTROL ACT, 1993

LOI DE 1993 SUR LA RÉGLEMENTATION  
DE L'USAGE DU TABAC

Consideration of Bill 119, An Act to prevent the Provision of Tobacco to Young Persons and to Regulate its Sale and Use by Others / Projet de loi 119, Loi visant à empêcher la fourniture de tabac aux jeunes et à en réglementer la vente et l'usage par les autres.

## CANADIAN PHARMACEUTICAL ASSOCIATION

**The Chair (Mr Charles Beer):** Good morning, ladies and gentlemen. Our first witnesses this morning are representing the Canadian Pharmaceutical Association. Welcome to the committee. We have half an hour.

**Mr Ernest Stefanson:** Thank you very much. I'd like to introduce myself first. I'm a community pharmacist from Gimli, Manitoba. I'm the past president of the Canadian Pharmaceutical Association and former chairman of our PACT\$ committee, which stands for Pharmacists Against Cigarette and Tobacco Sales, and I'm currently giving lectures on one of CPhA's programs called Butting Out For Life, which is a smoking cessation counselling program to teach pharmacists how to counsel their patients to quit smoking.

**Mr Leroy Favang:** My name is Leroy Favang. I'm executive director of the pharmaceutical association. You have received our briefs. Our intention is to speak to the brief through some verbal comments and then when we're finished if there are any questions that you might have, we would be very pleased to respond to them.

First a few words about who we are. The Canadian Pharmaceutical Association is the national voluntary association for pharmacists. We represent over 10,000 pharmacists from sea to sea, and that includes pharmacists in all areas of practice, whether they be in community practice, hospital practice, industrial practice. That also includes a number of organizations. We represent the chain drugstore pharmacists as well as the independent pharmacists, so it's the full spectrum. In many respects then, we would be referred to as the umbrella organization for the professional pharmacists.

Since the 1970s, we've been involved in the policy question of the sale of tobacco products in pharmacies. We've always pushed forward the position that tobacco sales are incompatible with the professional image of pharmacy, realizing that the profession was divided on the issue. But we really felt that our main concern or our main *raison d'être* is health. So the growing health concerns of the public have overridden any kind of apprehensions we might have about the economic implications of the removal of tobacco products in pharmacies.

We recognize that the profession is divided on this particular issue, but as the national pharmacy association, we believe that the majority of members do in fact

support the removal of tobacco products from pharmacies. So we stand firmly behind the principle and firmly behind Bill 119. We commend the government of Ontario for supporting the bill and also commend the opposition for their support and careful consideration of the bill and for agreeing to the bill in principle at second reading.

**Mr Stefanson:** Canadians visit their pharmacies because they need medications that can improve the quality of their lives. How inconsistent it is to see a patient walk out of a pharmacy with a carton of cigarettes in one hand and medications in the other. The irony is that tobacco, when taken as directed, will lead to death in many of its habitual users and that medications are taken to improve the health and wellbeing of the individual. It is because of this inconsistency that we believe that pharmacy should be out of the tobacco business.

The effectiveness of some medications can be reduced by smoking. As a pharmacist who does not sell tobacco, I have greater credibility to counsel my patients on these perils.

**Mr Favang:** In February 1986, an independent survey was done on the program which we were conducting at that time called the Stand Up and Be Counted program. This was a joint program between ourselves and the federal government department of Health and Welfare.

The program urged pharmacists to voluntarily give up the sale of tobacco products. The characteristics of that program back in 1986 were that there were three levels of participation.

The first level was those pharmacists who really agreed to distribute within their pharmacy educational material on the problems, the perils, of tobacco smoking and the difficulties associated with that and the implications on their health. The second level were those pharmacies which still continued to sell tobacco products but would not promote or advertise them in the pharmacy. The third and highest level, of course, were those pharmacists who agreed to voluntarily give up the sale of tobacco products. So you can see where we're gradually weaning people towards that end objective.

After the program was over, we had this independent study to determine the effectiveness of the program and, really, whether it was worthwhile. According to their findings, they said that the customer support for the Stand Up and Be Counted program was very favourable. In fact the higher the level of participation of the pharmacist in the program, the greater the customer support for that particular pharmacy.

It was apparent even back then that the removal of tobacco products from pharmacy gave pharmacists a sense of public approval. This was really very important to the profession, because as the gatekeeper for medicines in Canada—pharmacists improve the health of nations—they felt that it was important not to be caught up with



the stigma of the sale of tobacco product, which is the number one leading cause of death in Canada.

We believe the passing of this bill and the removal of tobacco products from pharmacies pays dividends to pharmacists many times over. It not only increases their understanding and image with the public that pharmacists' first role is the health of the patient, but it also improves the pharmacists' own sense of self-esteem and that they're working in that direction. The public support for this provides the dividends which will overcome any of the economic implications that are associated with this.

**Mr Stefanson:** The Stand Up and Be Counted program was followed by a program that we called PACT\$, which stands for Pharmacists Against Cigarette and Tobacco Sales. This was an initiative by our association to encourage and assist pharmacies to discontinue tobacco sales by providing them with a how-to kit.

This program was reasonably successful, albeit with independent pharmacies. The kit provided pharmacists with the public relations materials to help them realize community support for their actions and provide alternative product lines to substitute for their tobacco. Our association also dedicated an issue of our association journal to the tobacco issue.

A survey conducted in 1988-89 revealed that despite the resources channelled in this area by CPhA, only 12.7% of pharmacies that replied to the survey did not sell tobacco. Ladies and gentlemen, this is not a record to be proud of, but it's a record that you, through the work of this committee, have a chance to reverse.

Subsequent to the PACT\$ program, a survey was undertaken by the association in the spring of 1991 that focused on those pharmacies that had been identified by CPhA as being tobacco-free. The purpose of this survey was to identify practical alternatives which would maintain customer loyalties and offset lost revenues in those pharmacies that stopped selling tobacco products.

The survey revealed that almost 69% of the stores which reported a ratio of tobacco to total sales indicated that cigarette sales were less than 10% of their total sales, and half the stores reported that there had been no changes in their sales or that their sales had actually improved. Over 50% of the stores reporting on customer traffic indicated no change or an improvement in the number of customers in the store. Several actually commented that their average sales increased during that period of cessation of tobacco sales.

The conclusions drawn from the survey were that pharmacists determined that ceasing tobacco sales generally provided positive results in the long run. In our handout we have some further statistics that you may wish to look at.

0910

To you, members of this committee, this may merely be a list of statistics, but to me, Ernest Stefanson, a pharmacist from Gimli, it means much more. I am statistics in action. In 1985 I decided to stop selling tobacco in my community pharmacy. This year, almost a decade later, I have reached my 25th anniversary in my pharmacy. It has survived and thrived despite the removal

of tobacco, and I believe that both my customers and I have benefited from this decision.

Like the Canadian Pharmaceutical Association, the Ontario College of Pharmacy and the legislators of Bill 119, I chose to take a proactive, front-runner role on what is considered as not only a pharmacy issue but a public health issue. Our association recognizes the potential financial impact that cessation of tobacco sales may have for its members but believes that a transition period is essential to permit the orderly planning for a successful tobacco-free conversion by substituting other product lines and thereby reducing the potential negative financial impact.

Government must also realize that the profession of pharmacy is under considerable economic pressure from other sources; namely, the Ontario drug benefit formulary reductions, a recessionary climate and Bill 81. It is critical that government be sensitive to the compound effects of these influences. For example, if Bill 81, a piece of legislation now presumed dead, resurfaces in some other form in 1994, the combined effects on our members might be devastating.

To request the profession to accept a clawback of \$30 million on the professional fee in addition to the loss of revenues from cessation of tobacco sales might be a double blow which some of our members would feel seriously. For these pharmacists, being squeezed at both ends may indeed become a question of survival. But let me restate firmly and clearly that the sale of these products is incompatible with the role of the pharmacist as a health care provider. For this reason, CPhA supports those provisions outlined in the legislation that prohibit pharmacy tobacco sales.

**Mr Favang:** Because tobacco is a public health issue, I'd now like to make some comments that will not be on the bill, which are not really covered in the bill itself.

We feel, as part of the larger health community that has examined the Ontario Tobacco Control Act, there are a number of areas in which the bill could be tightened up, enhanced and made more effective from a public health measure. These would include the banning of chewing tobacco, snuff; the banning of the kiddie packs, the smaller sizes, which we believe could be done through packaging regulations; banning the advertising and promotion of tobacco products either directly or indirectly through tobacco industry promotional corporations; and beefing up Ontario's workplace smoking legislation.

We also understand that the standing committee has received a submission from the Ontario Campaign for Action on Tobacco, OCAT. We make specific reference here to the recommendations on the advantages of plain packaging and we support those recommendations.

**Mr Stefanson:** In conclusion, I will mention that I have a 16-year-old daughter, Sigrid. Like any parent, I want a healthy and happy life for her. As well, I want her to be able to respect me and what I do and what all pharmacists like me do. We work hard in an honourable profession that has such capacity to serve the public. What message does it send to Sigrid and other kids like her to see a man or a woman in a white coat dispensing

tobacco? Thank you. That concludes our presentation.

**The Chair:** Thank you for your presentation and also for the documentation you have sent to us. We'll begin the questioning with Mr Winninger.

**Mr David Winninger (London South):** As you may know, we've heard a litany of complaints from pharmacists accusing the government of discriminating against their retail operations. Perhaps the most extreme proponent of this view appeared yesterday. That was Mr Graham Stebbings of the Throop Group. This, in a nutshell, is what Mr Stebbings had to say:

"There is only one legitimate and acceptable survey and that is the one conducted by the Ontario Pharmacists' Association, which represents the economic interests of all 8,000 pharmacists practising in this province. That survey found 62% in favour of continuing the regime of having the decision to sell tobacco a voluntary one."

To wrap up, he says:

"All other surveys presented to you do not have the sanction or the legitimacy of the Ontario Pharmacists' Association. Not even the Canadian Pharmacists' Association survey is accurate; it was conducted with a small sample and it's not Ontario-based."

Could you comment on that?

**Mr Favang:** I certainly don't intend to comment on the OPA survey, but certainly in the framing of any survey question how the question is worded can have a very major impact on the answers that you get in that. I would suggest you look at the actual question and how it was worded in order to draw conclusions on the results of that survey.

**Mr Winninger:** I see.

**Mr Favang:** We stand behind our survey comments.

**Mr Dalton McGuinty (Ottawa South):** Gentlemen, thank you very much for your presentation. Let me begin by commending the work that you have done and your predecessors have done on behalf of your Canadian Pharmaceutical Association to remove tobacco from Canadian pharmacies.

One of the issues that concerns me personally is whether we should be doing that or you should be doing that—the government is in that certainly. As a personal preference I would far prefer that pharmacists work this out among themselves. I gather that you have concluded that you have gone as far as you can, practically speaking, in terms of encouraging your members. Am I correct?

**Mr Stefanson:** Yes, you are.

**Mr McGuinty:** Tell me, nationally, are tobacco sales permitted in pharmacies in all of the provinces?

**Mr Stefanson:** Yes, they are. It's very similar to Ontario that tobacco is sold. As you well know, this is just a North American phenomenon. People who come from Europe and other countries are just astounded that pharmacies in Canada and the United States sell tobacco. They find it very strange.

**Mr McGuinty:** Right. On page 9 you have a definition of a pharmacy. I think that's important for us to consider as members of the committee. Just so I can get

your position on this, it becomes somewhat more complex when we're dealing with larger retail operations where the dispensary in relationship to the overall operation is quite small or perhaps even located on another floor or a number of floors away from the location where they're selling cigarettes.

Under the terms of your definition—for instance, in town here at the Bay, I think on the fourth floor there is a dispensary and on the first floor they're selling cigarettes. Would it be your intention in that case that, "Look, guys, you've got to pick one or the other"?

**Mr Stefanson:** Yes, certainly I think we agree with the way that the bill is worded presently and it does look after that. As we all know, people will just look for any kind of loophole and they will have myriad ways to circumvent the intent of the legislation. So I really commend the legislation, as it is written, to address those concerns.

**Mr Norman W. Sterling (Carleton):** Thank you very much for coming to the committee to express your concerns over the bill. I, like Mr McGuinty, have some concerns about the government getting involved in this, but I guess the part that I dislike the most about this debate over pharmacies and selling tobacco or not selling tobacco is that it seems to be a pharmacy issue.

No one has argued very strenuously in this room that by not selling tobacco in pharmacies the consumption is going to fall. As a legislator that's my primary concern. Quite frankly, outside of the pharmacy trade I don't know whether anybody really cares whether you sell tobacco or you don't sell tobacco. It might be important for your children in terms of your interpersonal relationship and that kind of thing, but I really don't know.

When I walk on the street and I ask people who are not embroiled in this thing they shrug their shoulders and say, "What are you guys talking about?" I guess I'm concerned that we're spinning our wheels here talking about this and we're not lowering the consumption.

**Mr Stefanson:** I personally think that getting rid of tobacco out of pharmacies is not going to make a major impact on consumption in Canada. I agree with you there, but I think it goes beyond that. It's the image that a pharmacy portrays. People go to a pharmacy to purchase their health care needs, and it's just so incongruous to be selling tobacco where you're also selling your health care requirements.

I think also it sends a very negative message to the young people of Canada. When we're talking the tobacco issue really we have to focus on the young people, because people in the 20s and beyond, very few of those start smoking. People start smoking when they're kids. Pharmacists are a relatively respected profession, and I think this really does send the wrong message that this professional group is also selling tobacco.

**0920**

**Mr Favang:** If I may, I think you're right. It's not going to have any impact upon the sales, but the symbolic aspect—by selling it in a health outlet the person who smokes or who might wish to smoke can rationalize that clearly the health hazards are minimal, because why



would a health outlet sell the product?

It's that inconsistency which reinforces to the person who wants to rationalize it that it is not a noxious or habituating product. So from that symbolic point of view I think it's really quite important to the public to clearly enunciate the public health measures.

**Mr Jim Wilson (Simcoe West):** Thank you, gentlemen, for your presentation. Just on this note about public perception, though, because I think maybe pharmacists have more of a perception of being health care facilities than what the public does, I've argued that most people we've talked to on that don't perceive particularly the large pharmacies as health care facilities.

The Environics poll that was released by one of the anti-smoking groups last week or earlier this week indicates the same thing: 66% of those surveyed felt that pharmacies are retail outlets and only 24% felt that they were health care retail outlets or health care facilities.

In fact, cannot the reverse argument be made? I'm sure you've been through this a thousand times in your careers. It's not too many years ago when I was in my teens and doing science projects at high school. The only time I ever went to a pharmacy was to get a prohibited substance, something I couldn't get at the local hardware store. So cannot a logical argument be made that perhaps we should be banning it in every other retail sector and moving it behind the counter in pharmacies, moving tobacco products there?

**Mr Favang:** I don't know if you've read this morning's *Globe and Mail*—

**Mr Jim Wilson:** I'm trying to get through it here. There are several cigarette articles.

**Mr Favang:** There is an editorial on that particular concept. I don't think society is really ready for a move in that direction, because to ban the sale of it from all outlets other than a pharmacy, you're really stating from a societal point of view that it is a hazardous, habituating product and the only reason for its sale is to get the person off the product.

Society would then be saying that there's no legitimacy in the sale and all efforts must be geared towards discontinuing smoking. If society as a whole agreed to that, then I think this concept has validity, but until there is support for that and recognition of that by society as a whole that kind of action would not be really successful, I don't think.

**Mrs Yvonne O'Neill (Ottawa-Rideau):** Gentlemen, we had some pretty graphic videos the other day about the smokeless tobacco, and you have it in your brief, although you didn't mention it. Would you tell us a little bit about where you see that product in Canada now and do you see it growing, the provision of this? We do seem to feel that it is attractive to both children and athletes and the role model that's connected between those two.

**Mr Favang:** Yes, that's right. It's the role model which is really I think resulting in this having more public acceptance by the youth. That, in some respects, might even be a more hazardous tobacco product than the other, but it's a relative measure.

Again it comes back to, how firmly does society want

to regulate these products? I don't think society has really grappled with this. This might well be the tip of the iceberg or the watershed product by which we could establish firmer kinds of controls, but unless there's a social will that we have to mobilize all of our efforts to discontinue not the sale but the consumption of these products, then we will still continue to debate that issue.

**Mrs O'Neill:** Have you any ideas for us on this kind of product and nipping it in the bud, so to speak?

**Mr Favang:** If you feel that this is the product that we have to control sincerely from a health point of view and tighten it up, pharmacies are the place where you can expect that kind of delivery. If it's a regulated product, then you can hold pharmacists accountable for the sale of that regulated product under the conditions specified in the regulations, whereas you can't expect that of other retailers. So the mechanism is there; it's established.

**Mrs O'Neill:** So you're suggesting that this product should be sold only in pharmacies.

**Mr Favang:** If you agree that there's no legitimate use for the product and it should not be sold, anybody who buys it should be tried to be talked out of it, so there's no legitimate use for that product at all and the sole reason of restricting its sale would be to discontinue its use or consumption. If that's what you want, that can be done that way.

**The Chair:** The final question, parliamentary assistant.

**Mr Larry O'Connor (Durham-York):** Thank you for your presentation. I'm sorry, your name?

**Mr Stefanson:** Ernest Stefanson.

**Mr O'Connor:** Did you say you came from Gimli?

**Mr Stefanson:** Gimli, Manitoba, yes.

**Mr O'Connor:** That's where the CNR has its training school.

**Mr Stefanson:** That's right.

**Mr O'Connor:** I used to work on the Canadian National Railways as a conductor yard foreman. It seemed to me that there were an awful lot of hoppers, as we called them, engineers who used spitting tobacco. I just wondered then, in pharmacies out west, is that something that is another market, kind of a niche? It seemed to me when I was working in the railway a lot of these people chewed it. Just what are your thoughts on that?

**Mr Stefanson:** In our particular area it's not a major problem. It's really disheartening, though: In northern communities, especially a lot of the native communities, chewing tobacco is really on the upswing, especially among the young kids. It's a problem that they are having a hard time grappling with because it's not the obvious smell that you can detect from a child. I know it's a problem in our area that has been very difficult to handle and unfortunately is on the increase.

**Mr O'Connor:** When the Addiction Research Foundation made a presentation to this committee and was asked the question about reducing the number of outlets, for example, if taking it out of pharmacies would have an impact on the sales, they said yes, any reduction in the

number of outlets would. Somebody might well want to correct me here, but they said even if it's just a delay sometimes in the length of time somebody goes out and purchases it from someone else.

I guess the most compelling argument I've heard so far was from a pharmacist who came forward and said they've been working with some consumers and talking to them around cessation. They got their patch and everything, went up to the front checkout and, as they were leaving, there were all those cigarette packages staring them in the face and they decided they were going to buy the cigarettes. I guess it's kind of a contradiction, because you don't pay for everything when you go back to the pharmacy and you walk out and there they are.

We could see two pharmacists right out here in this mall: Shoppers Drug Mart selling tobacco, the other one tobacco-free. Both of them look like they're thriving businesses, both of them seem to be operating viably, so I think there is a role that pharmacy can provide, which is tobacco-free.

**The Chair:** Gentlemen, we thank you both very much for coming before the committee this morning.

0930

NGHIA TRUONG

**Mr Nghia Truong:** Ladies and gentlemen of the committee, good morning, and first a big welcome to our home town. You're right here in our backyard. I think probably it's wise for us to welcome you. For those who follow the lunar calendar, the Chinese and the Vietnamese among other people, we would like to wish you a happy new year. This is the year of the dog, and apparently it's very lucky if you're in the year of the dog. So we wish the government and this committee luck in all your deliberations.

I appeared before you two weeks ago as a cofounder of a group called Pharmacists in Support of Bill 119. Today I'm speaking to you as an independent pharmacist from the Ottawa area. Let me give you a brief history of my business. After that, I would like to expand for a few minutes on the falsehoods and the fallacies that you have been listening to for the last two weeks and present to you my personal observations regarding Bill 119 and its implications. Hopefully, we will have the time for you to ask me questions, and I'll try my best to answer the questions.

My company operates two pharmacies, one in the village of Merrickville and the other one here in Ottawa. Until 1992 this company had four pharmacies, two of them selling cigarettes. We took them out in 1987 and we didn't go bankrupt. As a matter of fact, when we sold to the present owners, we got a premium price. I will expand on that in a few minutes to get you off the myth that when you take tobacco out you lose your shirt.

My background is in chemical engineering from the States, and I have a doctorate in pharmacy from the University of Paris. I have been licensed to practise in Ontario since 1972. I have practised in France both as a community pharmacist and as an industrial pharmacist, and here in Canada I have worked in industrial pharmacy and for the last 20 years in community pharmacy.

I think I told you two weeks ago that I was quite amazed when I came to Canada to find out that in drugstores we can buy everything from soups to nuts, including tobacco. That was really a stopping point for me, and I have a lot of difficulty when I go back to the University of Paris—I'm a guest lecturer once in a while—and try to explain the pharmacy business in North America. This is always a sticking point.

I have a problem with the professors and my colleagues in France and in Europe that, "How could a health professional like you"—meaning here in North America—"carry a product which is deadly?" I have to find a lot of excuses, but it doesn't work. You can say a lot about economics, but the question remains that you are first a health professional. To paraphrase one of my professors, who by the way has already passed away, tobacco is a cancer. It's a cancer stick if you sell tobacco. You become a death merchant. Do you realize that?

But anyway, those are just rhetorical things. I would like to take this time to congratulate the government for bringing forward this bill and this committee for taking the time to go through it clause by clause and, in the final thing, for supporting this bill.

A few days ago, and even yesterday, the CEO of Shoppers Drug Mart and one pharmacist sitting on the council of the Ontario College of Pharmacists, in an effort to discredit the Ontario College of Pharmacists council for accepting the task force recommendations, stated that: "You should know that of the elected members who supported that resolution all but three were subsequently defeated in the elections that took place during...1991. They were voted out of office."

Let me please set the record straight, because I was part of that election. I think you should know by now that I was the one who got the resolution on tobacco, and I had to face the electorate, which is normal. Two things we have to remember: As a member on the council of a self-governing body, you may be elected by your peers in your district to go to the council in Toronto, but you are there not to represent the interests of your fellow pharmacists; you are there to represent the public interest of the province. Many of the councillors have forgotten that; they just forget, in due time, for whatever reasons.

Let's get back to that election. There were 16 elected seats to be voted on. There were five changes only, and they were all pro tobacco. One got in by acclamation in district 2 and four by election: district 1, which is where I belong; district 9, in the Niagara Falls area; district 12, in the Kitchener area; and district 14, in Sudbury and North Bay. So there were only five changes out of 16, not 13 out of 16. I don't know where he got those figures. I don't know whether they tried to trick the committee or what, but I hope that they got the matter straight.

Many of my colleagues and organizations have come to this committee, even in writing, to advance the proposition that tobacco removal should be voluntary. I think you have heard all the arguments. Very simply, voluntary doesn't work; we have seen that with the Canadian Pharmaceutical Association survey. Even at the college, after 10 years we knew it didn't work.



So we have to make a decision. It's a very difficult decision, but when you are elected to make a decision, you have to make tough decisions for the public interest, not for your members. I wish the committee to understand that. That's why the college took the position and asked the government back in 1991 to bring forward this type of legislation, because it is very paradoxical and incompatible for a health practitioner to carry a product which causes death.

"Tobacco is a legal product. Why shouldn't you let me sell it like other retailers?" But ladies and gentlemen, pharmacists are not just retailers, they're health care professionals. They're given the privilege to have a drugstore, meaning to be the custodian of prescription drugs, and the monopoly to sell drugs. With privilege, they must accept responsibility. They must not send a mixed message to the public, particularly to younger people who look upon the pharmacist as a person they mostly trust.

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I'm going to give you now my reasons and my personal observations of why tobacco should be eliminated from pharmacies. During my practice for the last 20 years, I have seen so many tragedies in my patients and I don't have to go over all the rhetoric about that.

For me there was always a conflict of what I was doing and what I was educated to do, meaning to promote health and prevent disease. That struggle ended one late evening shift when I worked in Kemptville. The emergency department called me and asked me to stay late to fill a prescription for a patient. "She needs it for her breathing problem." So we went through the whole thing. On her way out, she asked me to bring a carton of cigarettes. That was the straw which broke the camel's back. I could not look myself in the mirror any more. I had been telling my wife for so long that we had to do something about it because I have to live with my conscience.

So we took it out in all our stores. I don't have the liberty to release the figures because I have sold those stores to other owners, but I have had the blessing to give you some pictures. We took it out in 1987 on the first day of our new year, meaning of our fiscal year in 1988. We did not lose any revenue. We have increased our revenue by 10%. I can tell you how. The moment we did it, we got so much praise and support from our clients, from our patients and we had more new business than we can anticipate, but for me it's the message I have to give out, particularly to younger people.

I have been asked many times to go to schools to give little talks about healthy living and all those things. If all those young people came to my store and saw the tobacco I sell, they'd really be confused. On the one hand, they learn from their parents, we hope, and from the teachers that tobacco is bad, and go to Nghia Truong's pharmacy down there and get all those things there. Who would they believe, really? Right there, I drive a wedge between the parents and the teachers and everything.

In Ottawa-Carleton, the latest figures is 70% of pharmacies in this area are tobacco-free and very few,

none of them, have closed the doors or have major layoffs.

What I'm going to tell may be very provocative, but I'm going to tell you from the heart. I have seen many victims of smoking. The figures of 13,000 every year—100 in Ottawa, for instance, in each of our ridings—die every year, but those 13,000 people who die do not take their problems with them to the graves. This is where I'm being very provocative to you. They leave behind the physical, the emotional sufferings and the financial toll to their loved ones.

**The Chair:** Take your time.

**Mr Truong:** I went through those feelings six years ago when my father died of lung cancer. The man was six feet tall, and when he died he weighed 80 pounds. So I can really sympathize with Mrs Fraser, who came to you on the second day, when her late husband told her he wished he had never started smoking. My father used to say that. But we had warned him even before he had lung cancer, "If you smoke two packs a day, you're playing with trouble." Those things will never leave you.

This is why we, as leaders in our field, and you, as politicians, have to make every effort so that the children, our children, do not have ready access to tobacco products. With the problem we had last week of the decrease in tax, this bill must be strengthened.

I respectfully suggest to you that we need to have licensing systems on retailers for better control of sales; we need the plain or generic packaging to decrease the appeal of cigarette smoking to younger people; and we should enforce a smoking ban in all public places. We need the political will in this province to take those measures to protect our children. The ones who have already died, as I said, are gone. We have to protect our future.

I want to thank the following people who have helped me and who have really encouraged me in this thing, but before I do that, I would like this committee to appreciate the many pharmacists who came before you here or in their surveys, which I will share with you. They support this bill in a leap of faith to show to the government and to everybody that pharmacists are very serious in this debate and we're taking the side of the public health and the public interest rather than an economic point of view.

I strongly request this committee to explain to the minister the wish of pharmacists not to be further punished by measures in the ODB program which we have suffered in the last two years so that pharmacy as a profession remains viable for us to keep on providing good care to residents of Ontario, because our detractors will say: "You're crazy enough to go with this bill. You're losing your shirt and they're going to punish you more. Are you a whipping boy of the government?" No, we are doing this for the public of Ontario.

I want to thank Mrs O'Neill—she has really supported me and encouraged me—Mr Dalton McGuinty, Mr Hans Daigeler, Mr Chiarelli and Norm Sterling, who gave me a lot of advice, and Ms Gigantes for her support.

I would like to share with you two things. We have sent to every pharmacist in Ontario a survey, and in that

survey we asked one question: "I agree in principle with the no tobacco sales in pharmacies provision of Bill 119, the tobacco act. Agree or disagree?" If you agree, you can become members of our association.

As of yesterday, we have had 715 surveys returned to us: 499 signed members for our group; 104 support that provision but did not sign their names. So we have 603, or 84%, of the returns in favour of the ban of tobacco; 112, or 16% only, are against the tobacco ban. You can see the figures are there, ladies and gentlemen. I have included a letter from one of the pharmacists who wrote to us. Of course we have also received a lot of insulting letters, but that's part of the game.

**0950**

I also gave you a copy of the pharmacies in the Ottawa area which do not sell tobacco, and in the last page I got myself the pictures of the two rogues there. If you have kids who can't sleep, you can show those two pictures and they scare the heck out of them. I put those pictures there just to say do it. Do Bill 119. Not for those two guys, but do it, please, for my two daughters, because many years down the road from now, they will ask me: "When you were the president of the college, what did you do? Why didn't you do it? You had the chance to do it." So this is a very personal plea to you for my daughters and for all the children in this province.

**Mr George Dadamo (Windsor-Sandwich):** Thank you for your presentation. By the way, in 1979 my own father died from lung cancer from many, many years of smoking. He came from an environment and grew up in Europe where doctors said to him then that it's okay to smoke. They didn't know, and we grew up of course with smoke everywhere. He smoked in the car, smoked in the house. We don't know what those effects will be on his children in the years to come.

I sort of joined up late in this committee and I did a little bit of reading before coming on, but the line of questioning I have is I think basically simplistic and I haven't swayed from some of the questions I've gotten in the last few days. Do pharmacists not take an oath or something along those lines that stresses clearly that you're dispensing medicine and you're trying to make people healthy, in that cigarettes you sell at the front of the counter are sort of an afterthought?

**Mr Truong:** Mr Dadamo, it is a very good question you ask, because there's a code of ethics of the College of Pharmacists which says something in that line. Back in 1991 we were tempted to use the code to enforce it, just like the Quebec Order of Pharmacists tried to do, but our legal counsel have advised us not to do it. It would not be able to stand up in court because you cannot use a code of ethics to pursue a member. That's why we ask for legislation. As the college we can do a lot of things, but we need some teeth to be able to enforce it.

**Mr Dadamo:** In my estimation, it seems clear that people will come into your pharmacy to buy medicinal, they'll come in for other products, but cigarettes are not the main attraction. Correct? Pharmacies have said to us clearly that if they drop cigarettes, it's not going to mean the fall of the empire and the store is going to close; the actual sales or the profits that come in at the end of the

day are fairly low, so why do it? Why do you do it?

**Mr Truong:** I think probably most of the pharmacists and most retailers are afraid of the unknown. They say, "If I take tobacco out, I might lose all the accompanying sales." This is what they try to show you in the Coopers and Lybrand study.

But you have answered the question. For many of us who take tobacco out and who do it in a certain way—because you have to replace those. As a health professional you have many things: you have sports medicine, you have nutrition, you have homeopathy, so many new products. It's up to each operator to find the niche that his or her pharmacy is in.

Even Ms Stenzler, the CEO of Pharma Plus, has said that those pharmacies who did it did it in their own time. Why didn't they do it? The college has given them notice since 1991 that this is going to happen. They're waiting for the last minute to do it.

**Mr Dadamo:** Congratulations on your work. Thank you.

**Mr McGuinty:** Nghia, I want to start by first of all congratulating you for all of the work you've done in advancing this cause. I don't think anybody could doubt the sincerity and the sense of commitment you bring to this. You probably recognize that a great deal of the debate which has taken place in this committee centres around the issue you first brought forward as president of the college, so you should be happy to know you've caused us a lot of trouble.

Some would have us believe that this is all black or all white and that those who have some difficulties with the idea of pharmacists selling tobacco are somehow pro death. It would be wonderful if life was that simple, but it's just not.

I think the issue for me personally is whether pharmacists should remove tobacco from their stores or whether government should remove it for pharmacists. That's giving us a great deal of difficulty and we'll have to give that extensive consideration.

Has the college ever asked the government to do anything of this sort before? Do you anticipate it doing anything again in the future? Do you have concerns about this as a precedent? There's obviously some controversy, and it's been very difficult for us. I think it would be unwise for us to conclude that there's consensus regarding this issue among pharmacists.

Is there a concern that somehow you're setting a precedent, that this time you're asking the government to do something for you? You're taking a side. You happen to agree with the government this time. What about next time? What if another group of pharmacists come forward and they decide they want something done with which you cannot agree? How do you answer that?

**Mr Truong:** Let me try to answer those two or three concerns that you have. The voluntary approach is the best way, if we can convince everybody to do it.

**Mr Jim Wilson:** Then it's not voluntary.

**Mr Truong:** You know, during my presidency, when I had to go all over the province to explain to my col-



league pharmacists, I always stood up and said: "We want a voluntary approach. It's great. It has been 20 years though, guys, that we asked you this. So when are you going to stop it?"

I give them an analogy: "Let's say it was the time the GST was coming in. Let's say that Brian Mulroney goes there and tells you guys, 'Let's have a voluntary GST for the good of the country. If you want to do it, fine. If you don't want to take time to do it, fine too.' What do you think?" That was 1991, when the GST was there.

Voluntary things are great on paper. Philosophically, great. But when it touches the bottom line, it doesn't work. I know in North America we live in a democracy. You have to listen to your people. But there's a point in time that as a leader of a group or a community or an association, for the benefit of the public, you have to make a stand and you have to take a stand for the good of the public. I know it's very controversial, but if nobody does it, we will be smoking until the end of the day.

Your question is, tobacco is the first thing. The college or another group will come and knock at your doors next time. You have to understand, Dalton, what the College of Pharmacists is. The College of Pharmacists is a branch, really, of the government, almost an illegitimate child of the government, even though we deal at arm's length. But if the government asks the college to jump, we have to ask how high.

The college doesn't go and knock at the door of the government to ask for things like that. It has to come from within the membership, the councillors, the ones who are there to represent the public—not the way some of my friends think they are to represent the profession. They are confusing again. If they talk like that, they should belong to the Ontario Pharmacists' Association. They are not there at the college to represent the interests of their colleagues.

If the college, in its wisdom, asks the government to pass legislation, it's for the good of the public. Now, you may say sometimes, "What's next, if the college asks for some type of legislation which is different?" I think probably you have to give them the wisdom and the intelligence to come and ask the government, and of course the legislators, something which they can buy, really.

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**Mr Sterling:** I'm really happy you're here, Nghia. You know I've been involved in this whole fight against smoking, or the results of smoking, for seven or eight years. I started in 1985, and we've talked about it I don't know how many times over that period of time.

You may have heard me talking to the previous presenter about I'm not sure the public is involved in this debate as much as the pharmacy profession, but I do know of your hard work over that long time and I know how hard a worker you are in your business, along with your wife and your family, and I respect that gratefully.

I want to tell you the effect that someone of your stature can have on a member like myself. My tendency on this one would be to not be in favour of this, but you

certainly give me much more than sober second thought on this issue. That's how much I respect you.

**Mr Truong:** Thank you, Norm.

**The Chair:** Thank you for coming to the committee and sharing your thoughts with us. We appreciate it.

CANADIAN TOBACCO MANUFACTURERS' COUNCIL

**Mr Robert Parker:** Good morning, ladies and gentlemen. My name is Rob Parker. I'm here on behalf of my client, the Canadian Tobacco Manufacturers' Council, CTMC, for whom I act as president. Members of the association are the three major Canadian tobacco manufacturers: Imperial Tobacco Ltd; Rothmans, Benson and Hedges Inc; and RJR-Macdonald Inc. Our brief, I think, is in front of you. I will summarize the main points.

First, the tobacco industry supports the goal of eliminating tobacco sales to minors and therefore the principal purpose of this bill. We have been members for some time of a coalition active in this area. Samples of the 1992-93 material distributed by that coalition are included with the brief. Given changes in the law, including those contemplated in this bill, the material will require updating before it can be reissued later this year.

Second, along with other members of that coalition, we would urge the Ontario and other governments in Canada to find consensus on a common age of majority for tobacco purchase purposes. The existing legal ages of 16, 18 and 19, depending on jurisdiction, will, we believe, inevitably lead to confusion among both the public and retailers.

Third, while it is obviously being debated outside the context of this bill, the bill itself does not address what we believe to be one of the largest sources of tobacco for young people, the contraband market. We do not see how sales to young persons can be successfully eliminated when contraband continues and grows. In fact, to the extent that it narrows legal channels of distribution, and only to that extent, by banning sales in pharmacies and banning vending machines, the bill would in fact expand opportunities for illicit distribution.

Fourth, section 5 of the bill deals with packaging and health warnings. The drafting there appears to us to go beyond anything now contemplated by the provincial government in that it establishes legislative authority for a parallel second warning system in addition to the federal one, even though the provincial government, as far as we know, is not now contemplating that. This is therefore a delegation of power by the Legislature to the current or future lieutenant governors in council, permitting a major new regulatory action without future involvement of members of the Legislature.

Fifth and finally, we believe that the authority to regulate in some places is too general. Under paragraph 9, for example, "a prescribed place" is included without further definition in the list of places where smoking will be prohibited. That would permit, we believe, current or future cabinets in Ontario, without further public debate or legislative reference, to ban smoking entirely in Ontario in all public and private places, including private homes, and that would appear to go considerably beyond the stated purposes of the bill.

That concludes my summary of our submission and I'd be happy to try and answer any questions.

**Mrs Karen Haslam (Perth):** I'll ask you a couple of questions that I hope have a very brief answer and then I'm going to look at something in your submission. Do you believe that tobacco smoking causes lung cancer?

**Mr Parker:** I believe that consumption of tobacco is statistically associated with a long list of health ill-effects. These have been clearly documented in a huge volume of scientific studies. If the purpose of the question is exploration of the details of that, I'm not a qualified witness.

**Mrs Haslam:** No, I was merely asking for a short answer. Lung cancer has tripled in women. It's a concern of mine, and I know that this is it.

Do you believe we should be preventing our young people from starting this habit?

**Mr Parker:** Yes.

**Mrs Haslam:** Given that, I'd like to look at your submission, because you've brought forward some very technical aspects and I'm sure the committee does appreciate that.

Your very first point in your submission, though, says, "CTMC supports the goal of eliminating the sale of tobacco products to young persons." However, you talk about aiming your programs at encouraging retailers rather than looking at the tobacco industry.

The reason I'm concerned is that I have in front of me a "Compilation of Excerpts from Court Testimony and Exhibits from the Tobacco Industry Challenge to the Tobacco Products Control Act." What concerns me is documentation such as this: "Young smokers represent the major opportunity group for the cigarette industry; we should therefore determine their attitude to smoking and health and how this might change over time." That came from *Matinée Marketing Plans*.

This was Fiscal '88 Overall Marketing Objectives: "Re-establish clear, distinct images for ITL brands, with particular emphasis on relevance to younger smokers. Shift resources substantially in favour of avenues that allow for the expression and reinforcement of these image characteristics.

"If the last 10 years have taught us anything, it is that the industry is dominated by the companies who respond most effectively to the needs of younger smokers. Our efforts on these brands will remain on maintaining their relevance to smokers in these younger groups...." That also comes from *RJR-Macdonald*.

"Advertising implications: Export should continue to appeal to younger males who are sports oriented, drink beer, enjoy popular music, are most comfortable in blue jeans and T-shirts...." You are successful. My son started smoking at 19.

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The one that worries me the most is your media planning process. What you do is select magazines which deliver the largest target group for each brand individually. For *Player's Filter*, in English and French in men, your target group is 12 to 17 years old. In *Player's Light*, English and French, your target group for men and

women is 12 to 24 years old; *du Maurier*, women and men, 12 to 34 years old.

I'm very concerned about that, because that is well below any of the legal ages that you said were across Canada. I'm concerned because we see ads like this come out for *Virginia Slims*. Given that you said you're in support of eliminating the sale of tobacco products to young persons, given that your marketing plan goes for 12-year-olds, I feel that your neck would be a little red in the contradiction of both of those types of comments.

**Mr Parker:** Ms Haslam, I don't see any contradiction in it. I wonder if you could tell us the source of the specific quote that identified 12- to 17-year-olds?

**Mrs Haslam:** This came from exhibit ITL-13, Fiscal '80, *Media Plans*, an *Imperial Tobacco* document.

**Mr Parker:** Who prepared it?

**Mrs Haslam:** This came from a compilation of court testimony and exhibits.

**Mr Parker:** Yes, but was it written by *Imperial Tobacco*?

**Mrs Haslam:** It was a compilation of things—I believe it was, yes. Outline the target groups for each brand in 1980.

**Mr Parker:** Well, all I can tell you is that I don't believe that is an *Imperial Tobacco* document. It came from a very complicated and lengthy court case. I think you're quoting excerpts from a paper prepared by a professor at the University of British Columbia.

Certainly people begin smoking at younger ages. Once they get into their 30s, there's very little incidence of starting to smoke. So reference to younger smokers should not be taken as meaning smokers under the age of 18. All that I can tell you is that since 1989, there is no advertising done by any of the Canadian manufacturers, because the *Tobacco Products Control Act* forbids it.

Even if advertising still existed, the industry's position—and there was a great deal of evidence in the same court case on this point—is that advertising does not promote a decision to smoke. It is aimed at brand choice. Those two decisions are quite distinct and different from all of the research that the companies have done historically. I know of no reputable market research firm or advertising research in Canada that would support the proposition that advertising triggers the decision to use the product. That's a complicated—

**Mrs Haslam:** But marketing does target an age group. You do look for a type of lifestyle, an age group, a young person looking at certain—

**Mr Parker:** That is not a Canadian company and that is not a Canadian advertisement.

**Mrs Haslam:** My concern is, though, that the targeting and the marketing is, even in Canada I feel, geared to younger people. That does concern us.

**Mr Parker:** I would think it would. It concerns the companies as well. We believe that the choice to smoke is an adult one. It should be a choice made only by people over the legal age to smoke. The only way we believe that can be controlled is by both voluntary compliance by retailers and by informed and effective



enforcement. That's why we support this bill.

**Mrs Haslam:** I agree with the enforcement.

**Mr McGuinty:** Thank you, Mr Parker, for taking the time out to come and speak to us today. Are any of the members of the council manufacturing smokeless tobacco?

**Mr Parker:** No, I don't believe—snuff you're talking about?

**Mr McGuinty:** Snuff or chewing tobacco.

**Mr Parker:** As far as I know, none of our manufacturers manufactures that or imports it. It's a very small segment of the market. There is some imported from the United States. I'm not 100% certain, but I'm virtually certain.

**Mr McGuinty:** Right. Do you know if there has been any discussion or consideration given to beginning to manufacture it here in Canada?

**Mr Parker:** No, I do not. A point I should make is that the association represents the membership on common, non-competitive matters such as appearances in a forum like this and dealings with government on a variety of issues, as well as the media. Choice of a particular product—in the same category would be introduction of a new brand—would not be something that we would be informed about.

**Mr McGuinty:** How would the council respond to this government banning smokeless tobacco sales in this province?

**Mr Parker:** I can't answer the question because I haven't asked it of my members. A ban of an entire range of product—I guess the first question would be what the purpose of it is. If it would be included in the general ban of sales to young people then we would certainly support that. In fact, I assume it is included under the drafting of the bill.

**Mr McGuinty:** Yes.

**Mr Parker:** I would be happy to consult with the members if you'd like a response, but I simply haven't raised it and they haven't raised it with me.

**Mr McGuinty:** I would appreciate a response on that. It appears that, on the face of it, there would be no immediate economic impact on the members, since they're not in the business.

**Mr Parker:** That's correct, if they're not in the business of manufacturing it.

**Mr McGuinty:** I wanted to ask you a bit about packaging. I'm sure you're very familiar with this, but a number of presenters have argued that the package itself is a powerful form of advertising and that it's not covered by the federal legislation; that it ought to be addressed; that in the eyes of young people, a cigarette package is an accessory in much the same way as an article of clothing might be, earrings, a belt or the latest running shoes; that it's a powerful motivator for young people to get the package, get the cigarettes. How do you respond to that?

**Mr Parker:** I've read a lot of the material produced on this point. I certainly haven't read all of it. I think the fundamental position of the industry is that it continues

to confuse two quite separate decisions. One is a decision to smoke, the second one is a decision as to which brand will be smoked, which tends to change a couple of times during the first few years of somebody smoking.

We have simply seen no evidence, and the companies having sold these products for close to a century in at least one case, they have extensive experience in this area. They find no relationship between those two decisions: First, they choose to smoke, then they decide which brand. The first choice of brand is much more likely to be something that is smoked by their peers, smoked by their parents, smoked by an older sibling, simply because it happens to be available.

The package design, therefore, as a promoter of the smoking habit, is not a relationship that we regard as proved in any aspect. It's worth pointing out that the Chabot case before the Quebec Superior Court—Mrs Haslam quoted I think some extracts from testimony that was heard at that time—heard a large volume of material on the connection between advertising and package design and the decision to smoke.

The judge's conclusion was that all of that evidence was of no probative value and it was not considered as part of his final decision. When he was reversed by the Quebec Court of Appeal it was done on legal grounds, not on an evidentiary basis, and that was let stand.

**Mr McGuinty:** I have one final question for you: What reaction would we anticipate from the council in the event that this government enacted legislation to require generic packaging for cigarettes sold in this province?

**Mr Parker:** Plain packaging?

**Mr McGuinty:** Yes.

**Mr Parker:** No such proposal has been presented to the council so I'm speculating in some cases in this answer. Plain packaging would remove the only device by which the manufacturers can compete among themselves, which is the package design. It becomes a very moot point over what the choice is between one brand and another if the package designs, as a matter of law, are virtually identical.

There are a number of legal questions that enter into such a decision. I think it is safe to say that the industry would object and would argue very strongly that it's a misplaced initiative. Beyond that, until there is a formal proposal, it's difficult to comment.

**Mr Jim Wilson:** Thank you, Mr Parker, for your presentation. I note with interest your comments. I know you're a former member of Parliament.

It is a point we've made also that the government is seeking very widespread regulatory authority here and that crucial public health questions and the manner in which tobacco products will be dealt with and smoking in public places, in the future, simply will be done in secret in cabinet and not referenced to the Legislature. However, you may want to appreciate that over three years of this government, we have got used to their way of doing business.

Particularly in the future, I think the public increasingly doesn't want smoking in public places. In fact those would be good questions to put before future legislators,

but the government has decided to do it through cabinet process.

I did want to ask you a question. We've never really had, to my recollection over the last couple of weeks, the legal question that currently is before the Quebec courts. I believe it's the Quebec Court of Appeal. Is it with respect to labelling or packaging? Could you give us a summary of what the question is before the court?

**Mr Parker:** Two of the three companies launched court action on the constitutionality of the Tobacco Products Control Act, in particular its provisions banning advertising. That case has now been heard at the Superior Court level in Quebec and by the Quebec Court of Appeal. The Quebec Court of Appeal, as I indicated, reversed the lower court's decision on two points. It's quite a complicated case. Leave to appeal to the Supreme Court of Canada has been granted. That case will be heard, we expect, some time this year, although no date has been set.

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It is under that act that the package warning label regulations—which are now themselves in a state of flux because they are changing—a new regime will be in place by September of this year which requires redesign of all of the packages and a new set of eight warnings, two colour combinations to appear, larger than the current ones.

The companies asked the Supreme Court to stay that change until the court had heard the overall action because in effect the ground is shifting under the companies' feet. If the court, for example, hears the action and decides that the act is indeed unconstitutional, they will have changed all of the packaging, at a very considerable cost, under an act which would no longer have validity.

The court has not responded on that application for stay and the case itself, as I said, has yet to be scheduled but it will be heard.

**Mr Sterling:** Could I just ask a brief one on that: Has the Court of Appeal of Quebec basically said that the federal government then has the packaging control, or the right to make laws in that regard? Was that the question they're determining, whether it's provincial or federal jurisdiction?

**Mr Parker:** I'm out of my depth on this, Mr Sterling. I'm not a lawyer, period, and especially not a constitutional lawyer.

There were, I think, two separate grounds. The companies' cases, first of all, varied somewhat. The essence of it was the constitutionality of a ban on advertising; in other words, freedom of commercial expression under the Charter of Rights. There are related issues to that.

The first judge found that not to be justified; the second court found it was justified for a number of reasons relating to constitutional interpretation rather than, as I said, on the advertising evidence. That whole thing, of course, is to be reheard. Essentially, we now have two judges who have found in favour of the industry, two judges who found in favour of the government and it's to be heard by the Supreme Court.

**Mr Winner:** In your presentation, you suggest that the solution to contraband tobacco is reducing taxes and increased enforcement. Both of those have an enormous cost to this provincial government. At the same time you admit the wealth of scientific data that relate tobacco-related diseases to the consumption of tobacco.

I'm just wondering, since I believe you're a business person, how you justify this position and how you would suggest that our government pay for the enormous cost of health care related to tobacco consumption if we reduce taxes and increase money spent on enforcement. It certainly won't be the consumer who pays for that; it certainly doesn't appear that the tobacco manufacturers will be paying for that health care. Who then bears that cost?

**Mr Parker:** Society generally bears the cost of the health care system out of consolidated revenue funds in all governments. That's always been the case. There is a considerable debate about the heightened health costs based on consumption of tobacco. Claims have been made that the costs to the public purse of those health effects significantly exceed the revenues to governments from smoking, which are very substantial.

As I'm sure you're aware, the Ontario government itself, and alone, for several years, has profited from tobacco taxes to the level of about twice the entire industry level of profits. The same is true of all governments collectively; the figure is 10 times or better, probably closer to 15.

There was a study written, I think two years ago, by a former chairman of the Economic Council of Canada which examined the proposition that it was justified to charge higher tax prices on tobacco because of the health impact cost. There are two responses, one of which he studied. The first one is whether or not that allegation was in fact true. The conclusions of his study were that contrary to those claims, smokers constituted a massive \$3-billion- to \$4-billion-a-year subsidy to non-smokers. The study is available; I'd be happy to provide it to you.

The one thing he did not address, and it's the other part of the argument, is whether lifestyle choices should be subject to differential health premiums. Tobacco is a legal product. It does carry health risks that are statistically associated with it. So do a lot of other choices that people can make in society. The question is whether behaviour should lead to differential premiums.

If it's true for tobacco, should it also be true for those who eat diets with high levels of cholesterol? Should it be true for skiers or hang-gliders? To be faintly ridiculous about it, should it be true for people who take public transportation to work, which is demonstrably and statistically safer than private transportation? Now, that's a philosophical argument that I think has to be addressed if governments wish to pursue this course of inquiry.

**Mr O'Connor:** Thank you for taking the time to come before this committee. As committee members will certainly correct me, we do have the information about the court challenges. It's in our binders, so we know about the history of the challenges through the courts.

It was interesting that through our discussions, we've



certainly had a lot of presentations and a lot of people suggesting that we should go to a plain-packaging format. I guess part of the reason is that—I'll use the example when we were in Sudbury. Someone came before us and gave us this.

Of course, it's a drugstore, and we've heard those arguments, and that's not what this is about, but down here below—of course, it's for the jazz festival, du Maurier, and it's bright red, which of course is associated with that advertising that takes place millions of times every day in Canada with the package coming in and out of the pocket, which we hear isn't advertising and which, of course, is in compliance with the federal legislation that says no person shall advertise but for promotional purposes.

I guess this is why we're hearing so many people come before us saying that plain packages are essential. The intention of the legislators for the government of Canada, representing all the 40,000 who die prematurely from tobacco-related illnesses and the families and everything else, and the huge cost that it has on the economy for the illnesses and everything else is that this here—they put that legislation in to ban advertising because of that. They did it for all those people, and yet this here seems to undermine it. They've got that part in their legislation.

I just wondered what is your thought around not advertising for the tobacco company, but sponsorship.

**Mr Parker:** I was not a member of the Legislature of Canada at the time that bill was passed, nor was I associated with the industry. But I read the Hansards that connected with the passage of the bill.

Advertising was to be banned. The Minister of National Health and Welfare of the day, Mr Epp, introduced an amendment to the bill, which would permit sponsorship of charitable, cultural and sporting events by the companies and promotion of that sponsorship, the kind of thing you're referring to in the picture.

That provision was supported by all parties in the House. In fact, I think there were only one or two dissenting votes at the time. The purpose was obviously to allow the organizations that benefit from the sponsorship to receive that support and, secondly, to permit the companies to notify the public that they in fact were in fact supporting them. The amount spent last year on that kind of activity collectively in grants to the organizations involved was in the neighbourhood of \$50 million. It's up a little bit from two years before. We have done a paper which is available to you if the committee would like to see it. It goes back to early 1992 on that entire area.

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I think the nub of the question goes back to whether or not advertising or promotion or marketing—there are lots of names for it, but whether a display of the name or a display of the package or a display of an advertisement in fact promotes the decision to smoke or a choice of brands. We simply have seen no evidence that it does. There are jurisdictions in the world where wide-open advertising is permitted, billboards the size of football fields and so on in Hong Kong, where the smoking rate is significantly lower than in Canada, in fact has fallen

faster than it has in Canada. There are jurisdictions in the world where there is no advertising whatsoever where the smoking rate is significantly higher than it is in Canada. It's a connection that we believe does not exist.

I understand the sincere desire of people involved in this debate to eliminate or reduce smoking. We sympathize with it obviously in the case of young people below the age of majority. We think it is not a decision that people of that age should be making, and the only way to do it is to eliminate the contraband market and take the enforcement steps, many of which are in this bill, in the legal market. The advertising or promotion connection to the decision to smoke, I would simply tell you, in our view does not exist.

**The Chair:** Mr Parker, thank you for coming before the committee today and for your presentation.

**Mr Parker:** Mr Chairman, thank you for your time and for your questions.

Mr McGuinty, you asked for a comment on the industry's view on a ban on smokeless tobacco and whether I had any other document—

**Mr Tony Rizzo (Oakwood):** The report you were talking about.

**The Chair:** Yes, it would be useful to have that.

**Mr Parker:** That's the Raynauld Vidal on health costs. I'll provide both.

#### NATIONAL CAMPAIGN FOR ACTION ON TOBACCO

**Ms Janice Forsythe:** Good morning. Bonjour, tout le monde. Merci, Monsieur le Président. I'm Janice Forsythe and I'm executive director of the Canadian Council on Smoking and Health. I am here today on behalf of the National Campaign for Action on Tobacco, which is a coalition of organizations that are interested in reducing tobacco use in Canada and that work mostly on the advocacy side of the issue. The organizations in the steering committee are the Canadian Cancer Society, the Heart and Stroke Foundation of Canada, the Lung Association, Non-Smokers' Rights Association, Physicians for a Smoke-Free Canada as well as the Canadian Council on Smoking and Health. We act as convener of that coalition.

Some of our counterparts at the Ontario level may also have submitted and presented to this committee, but I want to emphasize that we are not here to supersede anything that they have said, only to enhance their positions.

I'd like to thank you for listening to us today and congratulate Ontario for the position it has taken on this terrible public health problem. You are certainly leaders across the country, and we're very pleased to see all-party support for this very important bill.

We've heard some people say that there are no studies showing that the ban on the sale of tobacco in pharmacies will have any impact on reducing consumption. We beg to differ; this is not the case. Rob Cunningham, next to me here, is a lawyer working right now on a contract basis with the National Campaign for Action on Tobacco. He's a lawyer and an MBA graduate of the University of Western Ontario, and in his studies over the many years that he's been working on tobacco control issues he has

take a very close look at this. His findings were published in the Canadian Pharmaceutical Journal and we've asked Rob to make a presentation based on his personal views as were indicated in the article. I'll now turn the floor over to Rob.

**Mr Robert Cunningham:** Thank you. I will be making a number of comments on other aspects of the bill briefly at the end, but I'd like to address this principal issue with respect to pharmacy. Let me first say that when I undertook this examination, my conclusion was not such that I was able to prove scientifically that consumption would decrease if the sale of tobacco was banned in pharmacies. That would be difficult or perhaps impossible to do. But what I did do was look at the available evidence and reasons, and my conclusion is that I personally have no doubt that there would be a decrease in consumption. A different question is how much that decrease would be, and that's something that I didn't examine in the article.

There are seven reasons that I would like to list fairly briefly, if I could, as to why there would be a decrease in consumption. You may have heard some of them previously.

One is price competition. You take away Shoppers Drug Mart and its loss-leader activity, its putting tobacco on sale: This has an impact of lowering the price among other retailers in the community. They want to make sure that they maintain their tobacco sales and the complementary sales that go with it.

If this happened and the price competition was such that there would be a 5% decrease in price within a community, that has, based on all the empirical research, about a 2% increase in overall smoking, and we've heard about this relationship in the tobacco tax debate.

The second reason: You ban the sale of tobacco from pharmacies and you get rid of a lot of advertising and promotion, inducements to smoke. Notwithstanding Mr Parker's position that advertising has no impact on primary demand, my view and the view of professors in my faculty of business administration who study marketing have said it's absolute garbage. A lot of jurisdictions in increasing numbers around the world are banning tobacco advertising precisely because they feel the impact has to be something that's addressed.

You have in most Shoppers Drug Marts and other pharmacies sponsorship advertising. You have huge displays. Now, these are inducements that the tobacco companies actively have their sales representatives encourage.

I'd just like to quote something from an Imperial Tobacco document. It's a confidential document that was produced in a court case, *Matinée Marketing Plans 1971*, and each copy is individually numbered. They wanted to make sure at the time that there was a very tight restriction. With respect to *Matinée*, this brand was targeted as one for women and positioned to be safer for health. So one of the things they wanted to do in the marketing plan and I'll quote: "Therefore we should put a certain amount of emphasis on vending machines, keeping in mind that *Matinée* could appear with an ad on vending machines in hospitals and health centres."

So back in 1971, when tobacco was more commonly sold to hospitals, they had this brand that they wanted to have perceived by smokers as being safer for health, so they wanted to have it positioned in hospitals and health centres. You've heard lots of individuals make representations about how the message of pharmacy as a health facility and tobacco is incompatible. The tobacco industry recognizes that link in confidential documents.

Third reason: You get rid of the sale of tobacco from pharmacies and you may have more health promotion messages. Right now a tobacco sales representative is going to object for sure if some pharmacist is going to have, above the tobacco display, "Smoking causes lung cancer; quit smoking, save money," or whatever other message there may be to discourage smoking. They may also object to the alternative nicotine products, such as Nicorette chewing gum, which we see have increasing promotions in pharmacies.

I mentioned this health promotion possibility to one chain drugstore pharmacist here in Ottawa a number of years ago, prior to the publication of this article, and what he said to me was, "We can't appear to do anything against tobacco." That's quite a statement and it shows how financial implications—and I refer to that quotation in the article—can have an impact on non-business decisions.

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The fourth reason: Reduced distribution. You reduce the number of outlets, you reduce convenience for the consumer and you'll reduce consumption. The Addiction Research Foundation—I've quoted from some of their previous research in the area of alcohol in the article, and I understand from Mr O'Connor's comments this morning that they've already made a presentation of how, in their view, reduced distribution would lead to reduced consumption.

The fifth reason is that fewer distribution outlets facilitate enforcement. It makes it easier, with fewer outlets, whether they're pharmacies or vending machines, to control the sale of tobacco to minors. We've heard pharmacists say, "We don't sell tobacco to minors; we train our staff." In the written material there are a few clippings: Shoppers Drug Mart was convicted of selling tobacco to minors, an item that Mr Sterling raised in the Legislature the day of the conviction. There's also the summary of a survey done at about the same time where 25 out of 30 Shoppers Drug Mart stores surveyed in Ottawa and Toronto on a compliance check sold tobacco to minors. Of the 25 stores that sold, 21 had signs up saying that they wouldn't sell to people under 18. We also have laws with respect to tobacco advertising and there's been a litany of complaints by health organizations that these aren't being complied with.

Shoppers Drug Mart, we know their relationship. They have a large, large number of tobacco promotions of various kinds within most of their stores, although less in the store that's in the Rideau Centre that some of you may have been in, in your stay in Ottawa.

I wrote to Mr David Bloom, chairman and chief executive officer of Shoppers Drug Mart. I'm a lawyer. I pointed specifically to various provisions of the act that



were being violated unequivocally, a registered letter asking for an explanation from Shoppers Drug Mart. I got no reply. That letter was written November 12, 1993.

The sixth reason is of course the relationship with Imasco. They own Shoppers Drug Mart. If Shoppers Drug Mart was no longer able to sell tobacco, the attractiveness of owning Shoppers Drug Mart would be substantially reduced. The synergy, the vertical integration of owning a tobacco retailer, perhaps the largest tobacco retailer in Canada, would be lost. If Imasco severed that relationship you may have new independence in Shoppers Drug Mart, producing a new attitude to tobacco control, an attitude substantially different from the one that we have at this point in time.

The seventh and final reason is that the ban on tobacco sales in pharmacies would result in an educational message to the public: "Hey, this is serious. You can't sell tobacco in pharmacies." That sends a message and may contribute, with other factors, to the decisions with respect to smoking initiation or cessation.

At the same time it'll have an impact on decision-makers at the local level: "Hey, yes, smoking. We should really tighten up our bylaws. This is serious business." So it can have an influence in stimulating interest in advancing other laws which would also have an impact in reducing tobacco consumption.

The Committee of Independent Pharmacists had a report produced by Coopers and Lybrand. I've only had an opportunity to give a cursory examination of this document, but based on my training I reject the conclusions, partly based on the methodology and partly based on the failed material that was considered. Only 13 independent pharmacists were interviewed, and these were all independent pharmacists who sold tobacco. Statistical significance is something that's missing. They didn't interview pharmacists who had stopped selling tobacco and what the impact was on jobs for them.

They did mention, "We want money to stay in our communities and so on and so on," but they didn't mention that 100% of the profit of the chain company, Shoppers Drug Mart, goes to Imasco; 40% of that profit goes to their parent company in Great Britain, BAT Industries. So where is that money staying in our community? That money is leaving the country.

If I may, I'd like to reiterate my support for plain packaging. If there's anything that this committee or the government of Ontario could do other than tobacco taxation to have the maximum impact on tobacco consumption within our community and with our young people, it would be plain packaging. I'll pass around a little plain package that I've prepared. There are different models of plain packaging which you may have already seen before the committee. That's one such way. The brand name is found in small print on the end.

There were a couple of questions that have come up, one with respect to the new federal law, the Tobacco Sales to Young Persons Act. That was proclaimed in force last Tuesday. Its regulations are law today. So most vending machines in Ontario are illegal and have to be removed, as of last week. That's already in place and the only vending machines that are left are the ones not

covered by the federal law. With respect to a question that came up from Mr McGuinty with respect to smokeless tobacco, I can confirm Mr Parker's understanding that there is no smokeless tobacco produced in Canada; it's all imported. So there wouldn't be that economic impact if the committee made a decision in that area, which I would support.

With respect to the case in Quebec, I've also written an article with respect to the constitutionality of the ban on tobacco advertising prior to the case being argued. I vigorously supported the constitutionality and, my having seen the evidence, some of which was cited this morning, some of which I cited and, contrary to what Mr Parker said, some of which was cited by the Quebec Court of Appeal, that level of court did cite some evidence that was not cited by the judge at the trial level in supporting their decision that the law was constitutional.

I'm very confident, and so are health organizations, that once we get through the system, there will be a very strong decision from the Supreme Court that the ban on tobacco advertising is constitutional, especially with some recent decisions that were not available at the time the Quebec Superior Court made its decision. There have been some more recent decisions on commercial expression that really give a signal that the tobacco advertising ban is going to survive very successfully.

One thing that was also decided this week was that five national health organizations were granted permission by Mr Justice John Major to participate in the hearing of that case as intervenors. So the health perspective will have added presence at the Supreme Court, not just the Attorney General of Canada. The intervenor status was opposed by the tobacco industry, as it was at the lower courts. The health organizations did not participate in the trial at the Quebec Superior Court. That may have a further impact.

In the document that you have, I've made some comments with respect to enforcement. Some of them are technical and detailed and legal, but I would commend them to your consideration. If I may highlight one and say we're having this real problem at the federal level with tobacco companies and compliance with the ban on tobacco advertising, there have been occasions where the federal government has said: "This is illegal. Stop this particular type of activity." The tobacco companies say: "No. We think it's legal. If you don't like it, take us to court." But then when we get to court, they say, "It's unconstitutional," and we have to wait through the legal hurdle as well.

What I would like to see the committee consider is something we find in the Ontario Business Practices Act where it's possible to have a cease-and-desist order to order corporations to have compliance. They can appeal this order, but in the meantime they must comply. Given the past behaviour of the tobacco companies, who fight like the dickens with respect to any measure that can have an impact on their profit, this type of added enforcement provision could be of tremendous benefit, particularly when we recognize that we would like to have laws that we can enforce successfully.

That concludes my oral comments. We'd be pleased to

answer any questions the committee may have.

**Mr O'Connor:** Thank you for your presentation. Noting that you're part of the national action campaign, I wonder, given that the federal government has proclaimed its legislation, and noting we've been around the province and we've seen these vending machines in lobbies and what not, do you know what kind of action the federal government might be taking to get these out of these places? Because they are obviously now against the law.

**Ms Forsythe:** The health groups met last evening with federal Minister Marleau and we have been assured that they are stepping up the negotiations with the provinces on the enforcement mechanism to be put in place for the Tobacco Sales to Young Persons Act. They have added 300 investigation officers, so there are some wheels that are in motion, but we don't have a definitive plan at this stage.

**The Chair:** Am I not right that there was a date on the federal bill? Wasn't it July 1?

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**Mr Robert Cunningham:** They had been expected to proclaim the bill so that it would be in force, but because of the tobacco tax matter they felt they had to proclaim it on an earlier occasion.

**The Chair:** But is there a specific date?

**Mr Robert Cunningham:** In the legislation, no. It was to come into effect on a date designated by the governor in council.

**Mr Sterling:** Nice to see you again, Rob. I don't know how long it is since we talked last. I saw you sitting out here and I didn't, until you came up and I saw your name and I started reading about you—it clicked, I guess, that it's four or five years, and I don't know if I ever did thank you for writing that nice letter in the Star or in the Globe and Mail about how wonderful the member from Carleton was on this issue.

**Mrs Haslam:** Who was the member then?

**Mr Sterling:** Actually, I don't know if I was the member for Carleton at that time. Anyway, I appreciate your coming here.

I was interested in your last point about the right of a government to stay or to stop the sale of tobacco or to have an interim decision of the government, while it's being tested in front of the courts, remain the law of the day in effect. I guess I'm a little concerned about doing that in light of the present scepticism towards our politicians. I wondered, is it a fair comparison between what we do under the business practices legislation and what you're suggesting here? Are there any problems with that?

I'm very reluctant, quite frankly, to say to any government—maybe that's because I'm in opposition at this time—"You can legislate whichever way you want," and even in the face of the Constitution it may tempt legislators to step beyond their bounds and then say: "All we'll do is we'll stop it for two or three years. We'll put up a tremendous fight in the courts and legislate where we really don't properly have jurisdiction." I guess it's sort of a two-edged sword, looking at it from a point of

opposition politics in terms of not agreeing with whatever the government—now, I would agree with what you're saying here on this issue, but I wouldn't agree necessarily with other steps.

**Mr Robert Cunningham:** Sure. I recognize the concern as a legitimate one. The Business Practices Act has different tiers of options. First of all, they give the responsibility to a director. It's not at a political level. We see this type of responsibility at the federal level: for example, the director of investigation and research for the competition bureau. It sort of has some quasi-independence. That's one thing.

They also have different things: They can have an order for compliance and then it can be appealed. They can have another level where they can say order and comply, pending an appeal. So it would only be in a more serious situation where you'd go to that step.

The tobacco companies would still have the option that they would even seek an injunction to avoid compliance. If there are still constitutional issues that remain outstanding, they may do that, but the constitutional issues are going to be resolved. We're going to see them at the federal level. They're going to be resolved soon, and then it's not merely constitutional issues but compliance. So they would have mechanisms through the Divisional Court in Ontario to challenge that. But once you've gone through that a couple of times and the courts say, "That's fine," and in fact, the courts do say that and I expect they would, then I think the courts would be permitting as directed.

**Mr Sterling:** When you were a law student, several of you laid some private information against Shoppers City, I think it was, for selling to minors. I've suggested to various different groups in terms of the vending machine issue that basically most vending machines in Ontario, and in Canada, I guess—Ontario in particular because I know—were illegally selling cigarettes to minors. They have been for the last five or six years. I suggested to the heart and lung people or whoever to go through the same process you did when you were a student at the University of Toronto, and they seemed to be reluctant to undertake that kind of process.

If a 14-year-old went up, put money in a cigarette vending machine and took the cigarettes out, the owner of that vending machine, as I understand the law, could be charged with selling cigarettes to the minor.

**Mr Robert Cunningham:** I have the same understanding. I think a lot of people who don't have legal training, some people, are intimidated by the legal process and if they were to initiate something—

**Mr McGuinty:** It's not the process; it's the bills.

**Mr Robert Cunningham:** That's a further consideration. So that may be a deterrent for a large number of people who would like to see compliance. I would support a provision that simply gets rid of vending machines so that you don't have to go through this more time- and cost-consuming stuff.

**Mrs Haslam:** I'd like to thank you for your presentation. It's been one of the most precise, most concise, most technical advising reports we've had and I really



appreciate that. I think the ministry appreciates the information from you regarding enforcement because I think we all agree that enforcement will make or break where we're going with this legislation. That's been part of a previous legislation, that there hasn't been an effective enforcement component, which I think was part of the thinking when we brought the legislation forward from the ministry, to look at the costs involved in any enforcement mechanism.

I believe that's why the model was brought forth, such as it is, regarding ticketing versus licensing. It's my understanding that licensing could be very costly both to small business people and to the ministry, upwards of \$1,000 per business. So the other way of looking at it was to look at ticketing and put that money into enforcement, rather than bringing in a piece of legislation that's costly and have no money left for enforcement. So I really thank you for those suggestions around the enforcement.

What I'd be interested to know is if you could expand a bit on one of your reasons when you talked about the drugstores. We've had Zellers and other mart people come and say, "We can get around this. We can put it as an owner-owned entity within a larger building, and that kind of a problem for us," building walls and things like that. Others have come forward and said, "If Zellers has to make a choice between tobacco and the pharmacy, we feel the pharmacy will be let go."

I've always wondered, wouldn't that focus more business to pharmacies? If Zellers no longer does prescriptions, wouldn't that go into the Shoppers Drug Mart, if Imasco decides to go with the drugstore in their sign instead of the tobacco at the front of the store? Wouldn't that be a more focused business to the real pharmacist so that when pharmacies come to us and say, "We're concerned," wouldn't there be a flow of business if this came about? You mentioned something about Imasco making a decision. I wondered if you would expand on that, if you had any thoughts on that.

**Mr Robert Cunningham:** I would agree with what seems to be the premise of your question that, yes, if Zellers was no longer selling pharmaceutical products, customers would have to go, for this purchase that they need to make, to pharmacies that aren't selling tobacco. These other pharmacies would then benefit from some of the traffic sales that are no longer going to places like Zellers.

**Mrs Haslam:** Would that counteract to some extent the flow of traffic next door to the confectioner for the tobacco, that at least they're increasing the flow of people into their store for pharmacy?

**Mr Robert Cunningham:** Would it counter it to some extent? Yes.

If I may, with respect to your comments on statutory prohibitions, I would really urge the committee to ensure that on the first conviction there is a short statutory prohibition period. This is what the Legislature in Nova Scotia has done and I believe the Legislature in Newfoundland. In Nova Scotia, it's seven days, and a longer period of time for subsequent offences. Here, we need the second offence. So that really gives a retailer a

break: "Okay, I'll wait till I'm caught and then I'll really try and comply." In the meantime, they may have sold several hundred cigarettes to minors. So that's one point I really urge the committee to consider.

**Mrs Haslam:** Thank you, Mr Cunningham. Again, I really do appreciate your presentation.

1100

**The Chair:** Final question, Mr McGuinty. Dare we finish with a lawyer?

**Mr McGuinty:** Thank you, Mr Chair. I may be a lawyer, but I assure you I'm not a QC.

I want to thank you both for your presentation. Mr Cunningham, I admire—what would I call it?—your ingenuity in your law school days in terms of bringing that matter before the courts and conducting that survey.

I want to get your legal opinion on a couple of things. First of all, what legal obstacles can we anticipate if we incorporate a generic packaging component in Bill 119?

**Mr Robert Cunningham:** First of all, Mr Parker didn't give a very complete answer on how tobacco manufacturers may respond. They may respond with a constitutional challenge. I think it would be easier for a court to conclude that plain packaging is constitutional than a ban on tobacco advertising. There are two reasons: One, I made a presentation at the National Conference on Tobacco and Health and I had 17 reasons why plain packaging would have an impact on tobacco consumption. I'm presently writing an article on that which will give you more detail.

But smuggling, it's clear that if you could have a distinct package like this, anything that doesn't look like that doesn't belong. That makes it a lot easier for enforcement in smuggling. There's no doubt there will be an impact. Given the importance of the contraband issue to a number of areas—I mean, you don't have to get to the question of whether it will have an impact on young people smoking.

Having said that, there is an increasing amount of evidence in Canada, in New Zealand and in other places of how generic packaging can have a tremendous impact. So you may have a challenge; we'll have to see what the manufacturers do. But I have no hesitation to predict the outcome would be successful for the government.

**Mrs Haslam:** Where can we reach you when we want to hire you?

**The Chair:** This is not supposed to be a business hearing. Thank you both very much for coming forward and for your submission. We appreciate it.

RUTH St LOUIS

**The Chair:** I call on Ms Ruth St Louis of the Pro-Medical Pharmacy. Bienvenue. Welcome to the committee. We have a copy of your written submission.

**Ms Ruth St Louis:** Good morning. I wasn't sure how this worked, if I had to hand it in earlier, so I'm glad someone came and asked me for it.

I'm an independent pharmacy owner who's worked as a dispensing pharmacist since I graduated in 1978, continually the whole time, except for two very brief maternity leaves. I opened Pro-Medical Pharmacy in

1986. It's located in a medium-sized dispensary in a medical building here in Ottawa. Pro-Medical has never sold cigarettes and never will. Given the size of the pharmacy, it was an easy decision, but there was no way I was going to ever have tobacco in my store, no matter what size it was going to be.

I strongly support the ban on the sale of tobacco in pharmacies. What made me decide to come was that before the hearings, all I heard were the loud voices of the opposition, which were pharmacy representatives saying how they were going to lose their shirt and all this stuff and that they were the best people to counsel about tobacco. I felt that most of these pharmacists were really not the front-line people; they were mostly the non-dispensing, administrative pharmacists. Having been in the field for so long and seeing the patients coming in with these tobacco-related illnesses, I felt there was just no question that tobacco shouldn't be in pharmacies. You can't in one corner sell tobacco and in the other corner fill the prescriptions for all the problems caused by it. To me, it's quite clear.

As health care professionals, of course our primary objective is to improve health and quality of life. To me, that choice was made when I chose the profession of pharmacy. Now that it's 1994, there's no doubt as to the hazards and everything associated with tobacco use. My big question is, how can something that has so many limitations on where it can be used find itself in a pharmacy, which is a pro-health facility? To me, it's always been quite clear.

I find it's a real shame that it has had to come to legislation, but I'm really grateful that it has. I think it will help a lot of the pharmacists out there who do work for companies that really are the decision-makers as to what is sold in the store. They're the ones dealing with the people on a day-to-day basis, but they really don't have a say as to what comes and goes in there.

I think with the legislation going through, it will eliminate the conflict once and for all, and the mixed message. I feel that it will send a stronger message to the people who say, "If they're available in pharmacies, they can't be that bad." Those people will start taking the health risks really seriously and decide what to do.

I really think restriction leads to more awareness. I know it's worked in our building. We worked for quite a while trying to make our whole building a smoke-free environment, because we had a small restaurant in there and it was the only place in the building that allowed smoking. He did decide to sell the odd tobacco. They're gone now and it's amazing how many employees who do smoke have come for help to quit or have quit. So I feel that a message really can be a mute message but it's there and people really do act upon it.

I don't have much more to say, except that, in closing, the fact that my store was a tobacco-free pharmacy attracted a lot of people to me initially. I'm surrounded by chains and people were coming because they wanted an alternative to, as one lady frankly put it, "those tobacco pharmacies." That's what she labelled them as.

But there's this one particular lady I'll always remember. She came into the store for the very first time.

Friends had told her that we didn't sell tobacco. She said she'd just lost her husband within the last month and she wanted all her prescriptions transferred to us because she didn't want to set foot in this pharmacy where she'd been for years and years.

She found that there was no way she could go there after they had sold her husband the tobacco that had killed him and then profited from the prescriptions that he needed as a consequence. I didn't know what to say to her. I just shook my head. You wonder, why is this still happening? Something's got to change.

Thank you for the opportunity of coming here.

**Mr McGuinty:** Ms St Louis, thank you very much for taking the time to come down and speak to us. I know where you are. My constituency office is on Kilborn Avenue, in fact.

We've had some presentations from people with considerably larger operations than yours. I'm just wondering what you felt about that when we get into stores like Zellers, or even we had the example, I guess this is the most extreme example, where the pharmacy is on the fourth floor and the cigarette sales are on the first floor in a large department store.

**Ms St Louis:** Where would that kind of store exist?

**Mr McGuinty:** The Bay. I haven't been following it that closely, but it's apparent to me that having a pharmacy on location is a marketing ploy. It's a draw to bring people in there, so we're seeing them in non-traditional settings, I guess. I'm just wondering what your feelings are about those non-traditional pharmacies.

**Ms St Louis:** I didn't realize there was a facility that large that had them so separate. I don't know. I basically feel that you have to make a choice. It's either prescriptions or tobacco. If tobacco is so lucrative to you, to anyone, then choose tobacco. To me, they're just two very different things, and they don't go together. It's like saying some person who sells insurance can go and tamper with your car just so he can raise your premiums. To me, it's basically the same thing. It's pretty cut and dried, in my mind.

I feel for these places, but a lot of pharmacies have voluntarily withdrawn cigarettes. I think they've benefited by it in the long run. I really feel that the pharmacists who are talking, especially from the large chains, are really the voices of non-pharmacists, basically. These people haven't dispensed in a long time. They really are cut off from the health issues. If they're voicing the concerns of Imasco, they're not pharmacists at all. So to me it's cut and dried. It's too bad, especially for the building that has a pharmacy on one floor and tobacco on another, but they're minorities.

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What's nice about Ontario is there are still a lot of independent pharmacies. I grew up in PEI, and when I was young, it was all independents. Then the chains came in, and now there's basically only Zellers and Shoppers Drug Mart. Everybody else is gone. So there's really no alternative; people only see day after day—you know, you walk in, you go by the tobacco, then you go get your prescription. When you walk out, you go by it again.



**Mr McGuinty:** I think you make a very compelling argument. One of the difficulties we face is that if we just consider the non-traditional pharmacies, I think there are many cases in which the people who call the shots there will opt for cigarette sales, and those pharmacists that are employed at Zellers or the Bay or K mart or Loblaw's, whatever, are going to be put out of work. They can't be re-employed, obviously, within those operations, stocking shelves or whatever.

**Ms St Louis:** If they have a client base, they can easily open on their own. I'm not sure how it's set up with Zellers, but I think the pharmacy itself is owned and operated by an individual, so you can usually find a location not that far away, especially if you have a business already set up, outside of these places.

**Mr McGuinty:** All right. Thank you.

**Mr O'Connor:** Thank you for your presentation and for coming before us. We've certainly heard a lot of arguments on both sides of this issue, and of course it's tied in with a bunch of other health facilities that are included in that portion of the legislation.

I come from a small town, and we still have a small community pharmacy that everyone goes to. I remember Mike Sheridan, who retired there. A new person came in, a young pharmacist. She does a terrific job, and everyone still goes back there. She's redesigned it a little bit and made it, I guess, kind of more modern-looking. But it's a terrific community pharmacy, and it's someplace where people can go in and talk to the pharmacist and have some comfort there.

I guess some of the dilemma in the way people have been putting it is that we've had, actually, representatives of the college come before us who said that, "The pharmacists that I speak up for don't want us to be banned from selling tobacco products." Mr Nghia Truong was here this morning and said it so eloquently, that the college of pharmacy is here to represent the consumers, the people who may have a problem at some point in time with the way they've been handled by the pharmacist. I guess the conflict we find ourselves in here then is that we've actually had people from the college who have come before us and said that, and the pharmacists from my area, and it's really kind of disheartening.

I see some young people coming in here. We've had a number of young people come before us, and we've had some pharmacy students come before us. You could see within them that they are going to go out there and practise pharmacy as health care professionals.

**Ms St Louis:** But that may not last.

**Mr O'Connor:** Well, maybe it will now.

**Ms St Louis:** Well, it will now. My first job was Shoppers in Summerside. I worked there a year before I moved to Ontario. A lot of the corporate head office didn't come to PEI that much. I think there was one store in Charlottetown and one store in Summerside, so they didn't bother us too much. We were pretty adamant about a lot of things, but tobacco was still up there in the front. At that time, I don't think a lot of us really took the issue seriously. It was 1978, 1979. But you become aware of how corporate head offices just kind of pull the strings.

A lot of times the pharmacist owns that dispensary, but the rest of the store is basically out of his hands.

So to me, I feel that a lot of those decisions are not made by that person in the back seeing those people; it's the people who have access to the front of the store. It's two separate things within the same store.

The reason I came here today is I want to represent the pharmacists who do the dispensing. A lot of us are busy out there making a living, because there are so many issues to deal with right now that a lot of us can't come in here. I was going to drop everything—family, business—and just come and make my voice heard to kind of offset those loud ones that we've been hearing so much.

**Mr O'Connor:** Good. Thank you for doing that.

**The Chair:** Thank you very much for coming down to the committee this morning. We appreciate it.

SOMERSET WEST COMMUNITY HEALTH CENTRE

**The Chair:** I call on the Somerset West Community Health Centre, Ms Sherryl Smith. Welcome.

**Ms Sherryl Smith:** Thank you very much, Mr Beer. I have three young people from our community here today: Kate McCarthy, Rosemary Robertson and Sean Graham. These children are 8 and 11 respectively.

I am the health promotion coordinator at Somerset West Community Health Centre, which is located here in Ottawa. It's a very urban, multicultural community. As a health educator for the last eight years I've really focused a lot of my attention on helping low-income women quit smoking, and I've seen the struggles that most of them have gone through. All of these children's parents smoke. I've watched women who are poor and are struggling with many economic issues in their lives and a lot of social and environmental stresses as well try to kick the habit, and more recently I've decided that although we can't forsake their needs we have to also look at the issue of prevention, so we've been really working much more at looking at preventive efforts. That's why we're here.

Most of the women I've helped to quit during their intake process have admitted that they started smoking between the ages of 12 and 13, so this is really very critical legislation and we applaud the government for having gotten it this far against some very strong opposition, well-organized opposition, and given the state of affairs with the taxation issue, we also think it's very important that you hang tough.

We certainly support the legislation as it is written in its entirety. There are a couple of issues that we would like to either reinforce or amend.

Reinforce the issue of plain packaging. Certainly there's tremendous evidence to show that that is a very strong deterrent for young people taking up smoking. The other issue we would like to see is some kind of very strictly enforced policing system. Licensing would be the ideal, but if licensing isn't feasible then certainly some very strongly enforced legislation with some real teeth to it because we know that the current legislation doesn't do very much good.

The opinions that I'm giving are on the basis of community meetings that we've had around the issue of tobacco access for young children. One mother who was

involved in these discussions suggested that a lot of people repackage their smuggled cigarettes, so the packaging is somewhat of a deterrent for the young people, but if we're really dealing with the smuggling issue, perhaps changing the colour of the filter tips might be another way of distinguishing the cigarettes.

So we got some very concrete suggestions and we've had some discussions with these young folks here as well and they've also come up with some interesting suggestions and some interesting stories that I'd like you to hear them tell.

Sean, do you want to start with your good suggestion?

**Mr Sean Graham:** I said that maybe you should put ingredients on the box of cigarettes so when people read them they would look at them and think that they're really bad and can poison them. If they don't read it they can like put a little chart on the wall and show them the ingredients in it.

**Ms Smith:** Do you want to tell your story about your friend?

**Ms Rosemary Robertson:** I had a friend; she was at a store about cigarettes. She tried to buy cigarettes and the store manager said no. Then he said, "Well, you have to give me a gold ring and then I'll give you cigarettes." Then she walked out with the cigarettes and that's it.

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**Ms Kate McCarthy:** My best friend has a friend who's only 13. She's really tall for her age. She walked into a store and she said, "Can I have some cigarettes?" She was only 13 and they thought she was about 18, 19. They just let her have as many cigarettes as she wanted, and she was only 13.

**Ms Smith:** I'd just like to finish. You'll see that in the attachments there's a poem written. It's a wonderful poem that was written by a young woman who participated in one of our cessation programs. This was sort of her inspiration, so I just draw your attention to that poem. I think it's terrific.

**The Chair:** Just to identify it, that's the one Nick O'Teen?

**Ms Smith:** Nick O'Teen. I think it says it all so well. It says it all.

**The Chair:** Would you like to read it?

**Ms Smith:** Sure.

"Someone we've known for a long time. I can still remember when I first met Nick—I thought he was so cool. All my friends hung out with him, and so I thought I would too. At first, I'd get really choked up when he was around—just like a teenage crush. But as time went on, I really got hooked on him.

"They say love is blind, and I loved Nick. All I could see was good in everything he did when we were together. When I was sad, he comforted me. When I was angry, he helped me calm down. When I was tired, he gave me a lift. I never felt lonely when Nick was nearby. Everyone told me that Nick was bad for me. I never listened.

"It took a long time for me to see the truth. Finally, now, I can say that I know Nick for what he really is: a

lying, cheating, good-for-nothing CREEP.

"He took all my extra cash—even when I had no extra cash. He took advantage of my trust, and got me addicted to poisons. He makes me sick! He stinks! And anyone hanging out with him stinks too! He tried to rob me of my future, but I didn't let him. I told him to BUTT out of my life.

"It may be hard to get on without Nick, but not nearly as hard on me as it was to have him around!

"So, I'm here today to say goodbye to Nick. So long, it's been bad to know you.

"Ashes to ashes, butts to dust.

"Goodbye Nick O'Teen. Rest in pieces."

This was a poem that she wrote the day she was quitting smoking. We've used it in our programs as sort of a eulogy, you might say, when the day comes for women to quit smoking.

*Interjection.*

**Ms Smith:** This was written by a participant in one of our programs, Mary Elliot.

**Mrs Haslam:** Sean, it was interesting for you to bring that up because we were talking about truth in advertising. We had a young person, a little older than you, come forward and say that instead of saying, "Smoking is hazardous to your health," what we should be saying is: "Smoking makes your face get wrinkles. Smoking makes your teeth turn yellow. Smoking makes you stink. You smell if you smoke."

I think you've hit on another good idea because we have 11 pages here of the ingredients of cigarettes, so it would be an awfully large package if we made the tobacco manufacturer put all the ingredients in tobacco. One of them is varsol, the chemical formula for Varsol, and the chemical formula for toilet bowl cleaner. Do you think that would be worth putting down: "These cigarettes could clean your toilet if you used them in a certain quantity"?

Do you really feel that type of advertisement would help young people? What age should we be aiming it at? You're 11 and statistically you're at a very vulnerable age now to start smoking. But there is still 11 to 19 and maybe even 20; there are another 10 years above you where you're at jeopardy of starting smoking. What could we say to you in the next 10 years that would make you stick to your guns and not start smoking?

**Mr Graham:** I'm not really sure about it.

**Mrs Haslam:** That's fine. That's an adequate answer and it's certainly something that we understand, that it is difficult for you at your age. It's difficult for us at our age to find that one message or the two messages or the education component or the enforcement component or the plain packaging component. Maybe we're looking for a simple answer when the answer is all of the above. Thank you very much, Sean.

**Ms Smith:** Do any of you others want to answer it? No?

**Mrs O'Neill:** Thank you so much, Ms Smith, for coming in and bringing your children. I feel quite strongly that cessation programs will have to be a very



strong component of the implementation of Bill 119 although very little has been said about them in these hearings. We know that smoking is addictive and that has been said quite often.

Can you tell us a little bit about the cessation programs that you've been involved in? We've heard about them being part of high school credit programs. We've heard about them being part of workplace programs where people will be given actually time out of the workday without any loss of pay. Can you tell us anything about the kinds of things you've done that would be successful? This poem seems to be very poignant. You must have some success stories, just looking at that poem.

**Ms Smith:** Actually, this story started about seven or eight years ago when I myself was trying to quit smoking. I was in a privileged position to be able to buy the service to help support me through that process. I was at that point working with a group of very low-income mothers who, when they heard that I was trying to quit smoking, indicated their own need to quit. When I started doing some research about programs they had access to that were affordable, there were none. I decided at that point to try to develop a program that was appropriate to these women and also very affordable.

That process took about five years and the program has been written up as a facilitator's manual. It has been printed and distributed across Ontario, is now being reprinted and translated and will be distributed through the Addiction Research Foundation.

The reason this program is effective is because we're not dealing exclusively with the addiction. We're really looking at some of the underlying socioenvironmental factors that once people are hooked they feel that tobacco products, the nicotine and the other chemicals that are in cigarettes—they become dependent on those both psychologically and chemically. It's the psychological addiction that is often the hardest one to really break.

A lot of these women have very stressful lives and are dealing with incredible pressures to survive. Tobacco is one thing they have control over. It's a power. It's a control issue for many of these women who are on social assistance and who often don't have any other controls in their lives, so holding on to their cigarettes is very important. We know that women smoke for reasons that are different than men. They smoke because of stress factors in their lives that often they can't deal with another way, or they don't think they can.

Our programs really look at those underlying fundamental issues and teach people how to cope, how to deal with stress, look at self-esteem issues, look at a whole bunch of different factors that are influencing people's need to find solace in an addictive substance. That's the approach that we use in the program.

**Mrs O'Neill:** Thank you for your perseverance and your ingenuity.

**Ms Smith:** We had some support. I think the Ontario tobacco strategy is timely, and certainly this population is a very needy population. One of the largest groups of new smokers is young women. Poor women and poor people are the ones who are still very addicted to the

product. There haven't been a lot of resources made available to support their need to quit.

My experience over the last eight years as a health educator is that 80% or 90% of people want to quit. If you ask them, they want to quit, but it's how to quit that's the problem. I'm here because I'm committed to that group but I'm also here because I don't want to see any of these kids in any of our cessation programs 10 years down the road.

**Mrs O'Neill:** And yet their mothers are very strong role models.

**Ms Smith:** Yes.

1130

**Mr O'Connor:** Thank you for coming today. Thank you for your presentation. You're a long way from voting age and this is a unique opportunity that we do have in a democracy like we have here in Canada and Ontario, that you can come before a committee of the Legislature and have a chance to have some real input into legislation before it happens.

Another opportunity I want to offer you right now is that—I'm the parliamentary assistant to the Minister of Health. I speak to Ruth Grier quite often. In fact, tonight I'm going to be sitting down and talking about some of what we've been doing in some of the committee hearings.

There's an ad campaign that's under way. You may have seen the ads, this Joanne ad, where this young girl goes into the bathroom and smokes a cigarette and that computer does that thing to her face. Of course, it's induced by that cigarette that kills over 13,000 Ontarians a year. If you had a chance to tell Mrs Grier what you think of that ad campaign—here's your opportunity. I'll let you say something to Mrs Grier and I'll take it to her tonight.

**Ms McCarthy:** I think it's pretty neat for some people, adolescents, who are thinking about starting smoking and when they see that commercial, they sort of get a bit scared and they will think about stopping smoking. That's what I think.

**Mr O'Connor:** All right, thanks. Adrienne, did you have anything you wanted to add, or Rosemary or Sean? Did you want to say anything to Mrs Grier?

**Mr Graham:** The part with the chemicals, we can name a few most common chemicals, not all of them. Like, some of them you can say over whatever number it is and here's some of them: You can put mercury and arsenic.

**Ms Smith:** Mr Chair, I'd like to also introduce to you Adrienne Turnbull. We were scheduled originally for 11:30 and she's come out of school and I'd like her to have a chance to speak, if you wouldn't mind.

**The Chair:** Certainly.

**Ms Adrienne Turnbull:** I'm not too sure exactly what has been happening but I'd like to say that as a high school student, I find that there's a lot of smoking around. I don't exactly enjoy it much and I tend to avoid it but I notice that essentially the thing that will really stop students is if you—well, essentially what won't stop

it is making the buying age different because they'll find someone else to buy them for them. Licensing will probably work, though. I think it's probably a very good idea because there are quite a few students in the—

**The Chair:** Thank you. I'm sorry to end it. We're a little ahead of ourselves. You weren't here at the beginning, but we also appreciate your coming down. Ms Smith, thank you for having the students come here and talking to us about tobacco. We appreciate it.

KARYL JAANUSSON

DAVID J. WALKER

**Ms Karyl Jaanusson:** We'd like to thank you for inviting us to share our views on Bill 119 today. My name is Karyl Jaanusson. My colleague is David Walker. We are both employees of Pharma Plus Drugmart in Ottawa. We each have had over 20 years experience as pharmacists and many of those as managers. We are on the agenda as Pharma Plus Drugmart with our names underneath it; we'd like to make it clear that we are here not has representatives of our company, but more as community pharmacists just speaking for ourselves.

Our purpose is to explain our position on Bill 119 and the proposed Ontario tobacco act, and our reasons behind that position. Our presentation will be brief, as we're sure you've heard many arguments over the last few weeks.

We are presenting together as our stores are similar in size, sales and trading area. Our stores are over 6,500 square feet and are like mini-department stores with four distinct selling areas: the prescription department, or the pharmacy, the cosmetics, general merchandise, and the tobacco area. Between us, we employ about 70 people, 25 of whom are full-time employees.

Bill 119 has caused us to split ourselves into our two halves, professionals and retailers. As health care professionals, we certainly support most of the objectives advanced by the Ministry of Health in Bill 119. As managers, however, of retail stores, we object to the proposed ban of tobacco sales by drug stores. I will be presenting our professional side; Mr Walker, our retail side.

As health professionals and personally, we agree that smoking is both a health and environmental danger. We agree with these objectives of Bill 119: to discourage smoking in children and adolescents, to decrease public exposure to secondhand smoke and to reduce the overall use of tobacco.

As pharmacists, the majority of our day is spent dispensing prescriptions, discussing medication with physicians and counselling consumers on the use, benefits and potential side-effects of both prescription and over-the-counter medication. Support staff such as pharmacy assistants do the technical jobs, such as counting, pouring, mixing, typing labels. Many times, after discussion with the consumer, we will suggest no drug therapy at all, for which advice we are not reimbursed.

The pharmacy in our stores today represents about 10% of our selling area, 25% to 30% of the store gross profit and almost 50% of the total store salaries. Profit in the pharmacy is generated through the dispensing fee or professional fee which is added to the cost of the medica-

tion to make the price of the prescription.

The pharmacy profit margin has fallen almost 20% in the past decade and 1% in the last year. The reason: the social contract and other efforts by the government to reduce the cost of the Ontario drug benefit program. The fee, which is frozen at \$6.47 since June 1990, was further cut back in September 1993, to \$5.86. Several drugs have been delisted from the drug benefit formulary.

Other drug plans are following drug benefit's lead and are pressuring us to reduce our fees. It is not uncommon for a prescription to cost \$100 for a month of medication. Of that \$100, \$94.14 is paid to the manufacturer or wholesaler for the cost of the drug. The balance is our profit. So the cost of drugs is increasing; the fee is decreasing. The pharmacy profit is being eroded.

Should our stores be pharmacy only, especially those stores with a high percentage of drug benefit prescriptions, we couldn't possibly survive. Support staff, such as pharmacy technicians, would have to be eliminated to cut down in overhead and the pharmacists would then be reduced to doing the technical aspects again and we wouldn't be free to speak to our customers.

Thus, with the economic squeeze being put on pharmacy today, we depend more than ever on our front-store sales to help us survive so the consumer has a dependable, knowledgeable, inexpensive professional available for medical advice at a time and place convenient for them. I'd like to ask Mr Walker to continue with the retail part of our presentation.

**Mr David Walker:** From our position as being retailers, we feel that this proposed legislation will be damaging to the profitability of our stores and, inevitably, there will be some job loss. The front shop accounts for about 70% to 75% of our total sales and it's these sales that help the dispensaries to operate in the professional manner which we both would like to see continue.

The component of these sales, which traditionally were tobacco, were about 10%, although recent activities with regard to black market smuggling and the federal move on taxation have changed this figure somewhat.

#### 1140

Our margin on tobacco is relatively low, but it has been a generator. Most customers who buy tobacco also add on to their purchases by buying personal care products, OTC products and the like. Under this scenario, if there was no tobacco, then there would be no reason for many of these customers to come into our stores, and I think this scenario points out that there would be a financial impact on our stores.

As an aside, we would suggest that the government of Ontario move to bring back into pharmacies all the medical-type products that currently are freely available in all sorts of outlets such as grocery stores so that proper services would be available for counselling the patients if needed.

We want it clearly understood that, as health care professionals, we absolutely and totally support the move towards reducing tobacco use in Ontario. In fact, personally, if Ontario became a tobacco-free society tomorrow, I would be extremely happy. However, we feel that



this bill will not have that desired effect of reducing the smoking but, in fact, will allow greater uncontrolled access to tobacco since it will still be freely available through the gas station, corner stores, grocery stores etc.

If the government of Ontario is serious about reducing tobacco use in Ontario, and we believe it is, then we suggest the bill should be amended. The government should make tobacco a controlled substance. We do not believe anyone denies that tobacco can be and is addictive, and we suggest that government and society should be moving in a direction that acknowledges the drug type of properties that tobacco use has. In fact, with the previous presentation, the reading of that poem Nick O'Teen, I think, highlights the destructive effects of nicotine.

We'd suggest that there should be a massive campaign to exercise the public that tobacco use is in fact a type of drug use. The outlet for supply of tobacco products should be a multipurpose facility with anti-smoking products as well as counselling services available. We do not—and I repeat, do not—suggest that this facility would be a drugstore.

The distribution of tobacco products through a tobacco control board, similar to the LCBO, would be the fairest and most consistent way of regulating supply, but also of treating retailers equally. However, this would necessitate the government giving all retailers a time period of five, seven, 10 years to adjust their operating procedures, lease renegotiations, replace lost products and adjust staffing through natural attrition.

In conclusion, we would just thank the committee for the opportunity of voicing our opinions and concerns.

**Mr Tony Martin (Sault Ste Marie):** It was again a good presentation of the way that you proceed with this whole issue.

For me this has been a really interesting, challenging, troubling discussion that we've been having for the last number of weeks. I guess the only word I can use to sort of describe in any way—I suppose there are others—is almost a schizophrenic happening where you have professional pharmacists very sincerely believing two different things here.

We have retailers who come in and share with us two perspectives on this. Some say, "We don't lose money"; others say "We do lose money," and it's almost like the devil playing with us. I've listened to one group of presenters tell me that and run by me all the facts and figures that tell me this is a deadly business to be in and 13,000 people are dying across the province every year. Then we have other people coming and tell us that, "Well, yes, that may be true, but still it's a legal substance and we need to sell it to make money." It just doesn't jibe. You have, in your own instance, Pharma Plus stores which are selling it and Pharma Plus stores which have decided not to sell it. How do you personally deal with that?

You sit at the table here, actually presenting to me the retail side and the professional side. How do you personally deal with that tug that must be inside of your head around the question of this being such a deadly

substance—13,000 people a year dying as a result of smoking—and yet it's a legal substance and we continue to sell it because it produces a profit?

**Ms Jaanusson:** It has always been a problem with myself as a professional in the fact that drugstores sell cigarettes, but it's been a traditional product in community drugstores, especially those of larger volume, ever since I can remember. Personally, I've never sold a cigarette. Cigarettes are at one end of the store and I'm at the other. Although I manage the whole store, I have nothing to do with cigarettes.

I don't agree with smoking and, as David said, I'd be very happy to see a smoke-free Ontario. I guess my objection would be the fact that we're being pointed out because people see us as a health facility where in effect we're partly health facility but generally just a convenience store to many people, like a grocery store or the corner store where people can go and not only pick up their cigarettes but they can pick up their aspirin, their Alka Seltzer and a lot of things that are of a drug nature which I don't think should be sold in those stores, but they are.

I would agree; as a professional I don't agree with cigarettes and I think they should be eliminated. I just think it's a bit discriminatory to pick all drugstores.

**Mr Walker:** I would concur with what was said. I would also point out that as part of the traditional drugstore economy, tobacco was used partially from the government's side also when it negotiated fees and things to say: "Well, don't worry if this fee's not good enough. You'll make it up out front." Now if at this point then you pull, suddenly, a portion of what has been part of the economy of operating a drugstore, then I think you have a potential and major effect.

But the more important thing is, by pulling it out of a drugstore, I personally don't believe you're going to reduce the usage of tobacco significantly, because you're not making it less available. It's still in all the other outlets.

**Mr Ron Eddy (Brant-Haldimand):** Thank you for your presentation. We've been presented with information where many pharmacists have made the decision to eliminate tobacco products from their locations and they're success stories. They say that although they may have experienced a reduction in sales because of that when they eliminated tobacco for a while, then things picked up and they were complimented by many people who agreed with them eliminating tobacco. It's a real success story and there are many of those. In addition, we have a list here of 64 pharmacies in this area who have eliminated tobacco.

I appreciate your mentioning the contraband, the smuggled cigarette situation and hopefully measures being taken will help to curtail that, if not eliminate it. I certainly hope so and I know many others do. But in view of the success stories and in view of the declining sale of tobacco products—maybe you're experiencing that—what do you think about the success stories that this committee's been told on many, many occasions since we've been sitting?

**Mr Walker:** I don't know personally all the people you're referring to. I would say, however, that their decision to discontinue was probably made by themselves, that this is appropriate point to do it. This legislation is proposing saying, "Everyone stop supplying tobacco."

**Mr Eddy:** I don't think we've been told by anyone that anybody who stopped selling cigarettes decided to go out of business. It seems to be a plus rather than a loss.

**Mr Walker:** As a business person, a business person would not make a decision to discontinue a product if he knew it would bankrupt him. So the people who discontinued did so because maybe that was not a large or significant portion of their business or whatever. I really can't answer for those people.

I think we've made it clear that neither of us smoke. We don't believe in smoking. We're not even saying that tobacco should be in a drugstore per se. What we're saying is that if you want to reduce tobacco consumption, then move towards a controlled supply but don't leave it in gas stations and whatever, because that doesn't go towards the ends of reducing it.

**Ms Jaanusson:** Also, I'd like to add that in our particular cases we're in malls where there's a lot of competition. There's Zellers very close by my store; there are grocery stores. If we didn't sell cigarettes a lot of our customers would go to those stores to pick up the cigarettes there, and those stores are now carrying a lot of the products that we traditionally have carried, like health and beauty aids and even some cosmetics in small amounts, that I think we would really lose the companion sales for those.

**Mrs Haslam:** I've been listening very carefully and as I understand it—you talk about profitability—you say that 75% of your profitability comes from front-of-the-store products and 10% of the 75% comes from tobacco sales, so that lessens the profitability out of 100% of tobacco. I question whether a store would go bankrupt on 10% of three quarters by removing one product. I seriously question that.

As Mr Eddy has said, time after time we've had companies and stores come to us and say: "Yes, it was a little difficult. There's little profitability in tobacco. It is a cash-flow situation for the store. We replaced it with a more profitable product, so we replaced it with something that makes us more profit, not just the cash-flow item of it. We replaced it with something that still brings people into our store." So I would question that comment in particular.

Number two, you talk about an appropriate point, some people having an appropriate point for removing the tobacco when in reality the Ontario College of Pharmacists has given notice since early 1989, 1990—task force continued to say that pharmacies should be removing tobacco. So in the last four years there should have been some downgrading and there should have been within the last four years an appropriate point for stores to remove those products from their store.

I think you bring it to the forefront. It ultimately is a matter of an argument saying that the presumption is that

the financial benefit supersedes the health benefits, and I think this committee has to look at the health benefits. I just ask you to make a comment.

**Mr Walker:** If we're talking four years or whatever, you must remember there are lease negotiations where rates are fixed over 10 years or whatever. However, the committee's concern is with health, and I think we've made it clear that our concern would be with health.

I'm personally not arguing that tobacco should be in the drugstore. What I'm saying is that the legislation, as proposed, does not have the desired effect of reducing tobacco consumption, and I think that would be the argument I would be using.

**Mrs Haslam:** If we reduce just one person's consumption and if we prevent just one child from starting—and we've had certainly proposals before us showing in that Brantford 28% of the high school students buy from drugstores. We had a 12-year-old in Thunder Bay buy from a Shoppers Drug Mart and Pharma Plus. So if that one child stops smoking, I think we have to consider that as a viable goal.

**Mr Walker:** I would concede that if one child stops, that's great, but if you can stop more than one, in fact hundreds, by having your supply controlled through proper outlets, and I would suggest gas stations and corner stores as being the supplier is not the right way to go—so taking it out of drugstores as one area is just discriminating. Make it a controlled substance if it's that dangerous, you know, and put it in a controlled outlet and provide the anti-smoking support services and all and, as I said, not in a drugstore.

**Mrs Haslam:** I agree. Enforcement is a major component of this piece of legislation. Thank you very much.

**The Chair:** May I, on behalf of the committee, thank you both for coming here this morning. We appreciate it.

Members of the committee, that concludes our sitting for this morning. We begin at 1:30 this afternoon here.

*The committee recessed from 1154 to 1334.*

NATIONAL ASSOCIATION OF TOBACCO  
AND CONFECTIONERY DISTRIBUTORS

**The Chair:** Good afternoon, ladies and gentlemen. Our first witness this afternoon is from the National Association of Tobacco and Confectionery Distributors, Mr Luc Dumulong, executive vice-president. Welcome.

**Mr Luc Dumulong:** Thank you. First of all, I would like to thank the standing committee for giving us the opportunity to present our views on the proposed law. I guess I could start by telling you what the association is all about and who we are and who we represent.

We are wholesale distributors of tobacco and confectionery products throughout Canada. We are the middleman, if you will, between the suppliers and the retailers. Our members serve 60% of all retail outlets in Canada, so we're pretty vast. Of course, the goal of the association is to foster better communication and a good flow of products, be it confectionery or tobacco, between manufacturers and retailers, and of course representing the interests of the wholesale members.

On our presentation per se, I guess I could start by



looking at the minimum age requirement. In the light of the fast-evolving situation these days in respect of tobacco and tobacco legislation and taxation and so forth, in our opinion we should have a universal minimum age. We, of course, are against youths smoking and we think that smoking should be a decision made by adults. We commend the effort of the Ontario government to curb accessibility of the product for youths.

This being said, if we start having different age requirements by different jurisdictions it might get confusing, especially in this portion of the province where we have a different age requirement now, and we have an age requirement throughout Canada that is universal, if I may say. So I guess our point of view on that would be of one age across Canada.

**Vending machines:** Of course, our members do distribute tobacco products through vending machines. We have to realize that over the past few years the legitimate distribution network of tobacco products has been experiencing a significant decrease in its sales, but at the same time this decrease in sales wasn't reflected in the consumption level that we see in the population, for obvious reasons.

Obviously, we have a huge contraband problem on our hands now and we're losing control of the tobacco industry. We know the manufacturers are making a lot of money on that. They have been making a lot of money recently, but we, the small operators, privately owned distributors and retailers, the clients of our members, are really hurting also. We see again what's happening here in Ontario and in Quebec: 40% of the total market here in Ontario is controlled by organized crime where you don't get any taxes and we don't get any business.

That being said, if we ban vending machines totally, what we'll do I guess we'll only shrink the legal distribution network of this legal product, giving even more incentive to the consumer, who might not get the chance to buy the product of their own choice easily enough, to turn towards the illegal market again, fuelling even more this huge problem on our hands.

1340

If we reduce points of sale, that's what is going to happen. We're going to fuel this contraband network again. I don't think it's very good for our society as a whole when we see that more and more it is socially acceptable to circumvent the law because of legislation that isn't in tune with what the population is inclined to accept. If we shrink this legal distribution network even more, and I have to stress this fact because we have this big problem now, of course we'll lose, because of this contraband, tax revenue for the government and we'll lose jobs at the wholesale distributing level as well as the retail level.

In pharmacies, the same thing applies. That won't achieve the goal of discouraging people from smoking because they'll be able to walk across the street or to the next-door store and buy their cigarettes. I think here again the same logic applies: Reducing points of sale will encourage even more people to turn towards the illegal market. The demand is there and if it's not supplied by legal means, it will be by opportunistic, organized crime

means. What do we do with small and remote pharmacies that sometimes depend on the sale of tobacco products to stay in business? Are they going to have to close down? I'm sure all these arguments have been presented before, but it's important to stress that. The banning of tobacco sales in pharmacies also raises serious concerns as far as we, the wholesale distributors, are concerned, because this measure in a way represents a first step on the part of the government to take control of the distribution of tobacco products in this province. I think this should raise a flag for us, definitely, because here again if we start selling cigarettes in liquor stores, by shrinking this distribution network, we're going to have those opportunistic guys going across the border and making tons of money: \$1.6 billion in 1993 that the illegal contraband network netted. It's a lot of money they're looking at there.

There's a need for the product and if it's not supplied by legal means, it will be by illegal means. I wonder if laws that would like to have people quit smoking or entice them to quit smoking really work. If people decide to quit smoking, they just quit. I guess the role of the government in that respect would be one of education. As long as we educate the public, it's the only way. I don't think coercing people will achieve a very positive response in many of them. We hear that more and more these days: "I'll do what I want. I don't like to be told what to do by the government, especially with a legal product."

Our recommendation would be, to start, a unified legal age for buying tobacco products. In terms of vending machines, although there's an accessibility problem to that special market, without totally banning vending machines, I guess we could leave those machines in a restricted area where we have a licensed establishment where accessibility is already restricted. I don't think that we need to ban vending machines totally. In terms of pharmacies, the decision should be left to the owner. Basically, that's it.

**Mr Jim Wilson:** Thank you, sir, for your presentation. I don't have any questions, other than to ask you how many members you have in the association. I guess secondly—I do have a question—do you know of any other provinces that have had the discussion about banning the sale of tobacco products in pharmacies? In particular, because I notice your address is in Quebec, has the Quebec government thought about that?

**Mr Dumulong:** I guess in light of what they've been deciding with taxation, as a PR move in a way, they said they were going to consider maybe banning sales in pharmacies, but I don't think we're there yet in Quebec. I know that in Ontario this dossier is much more advanced and the political will behind this proposal is much stronger in Ontario than it is in Quebec. Taking this into consideration, I don't think Quebec will go ahead. They might take this position as a medium, maybe, to appease the ever-powerful anti-smoking lobby in Ontario.

**Mr Jim Wilson:** How many members are in your association?

**Mr Dumulong:** We have 86 members from BC to Newfoundland. Maybe you can say, "Jeez, 86 members are not that many," but 86 members cover 60% of retail

outlets in Canada. We have big members, and smaller of course. We have independent and we have corporate.

**Mr Jim Wilson:** Do you know how many actual stores you would supply to?

**Mr Dumulong:** I don't have the actual numbers. I just have a percentage. Within our membership, it's very touchy to start telling these things, because in a way in association business you have competitors that are together under the same umbrella. They can get really touchy at one point in time in terms of their yearly sales and all these things. These are problems I have to work with in my membership. That's why we only can work with the percentages.

**Mr Sterling:** I have just a very brief question. Can you give us some idea of how much of your sales would represent sales in chewing tobacco and whether or not that's increasing at this time?

**Mr Dumulong:** Chewing tobacco is very marginal. It's by region. The more west you go, the more chewing tobacco you'll find. But all in all, it's a very small amount.

**Mr Sterling:** Is it increasing in Ontario or Quebec, or do you know?

**Mr Dumulong:** Chewing tobacco? I don't think it is increasing. Smoking is increasing. We all know that. I don't think I have to explain that. In terms of chewing tobacco, I don't think that it is. It's pretty stable.

**Mrs Haslam:** The National Association of Tobacco and Confectionery Distributors: What else do you distribute?

**Mr Dumulong:** Well, candy—

**Mrs Haslam:** That's what I was asking. Confectionery is candies, and tobacco?

**Mr Dumulong:** We also distribute what we call "small wares," the little articles that you find around cashiers: pens, things to hold your hair and all these things. Historically, our members were specifically distributing tobacco and confectionery, but with the evolution of the market, of course they would have to carry more lines of products and things like that.

**Mrs Haslam:** I just find it incongruous, tobacco and confectionery. The two of them together give me an uneasy feeling, when I talk about candy on the one hand and tobacco on the other.

Could I go into your report now? You talk about smaller and remote community pharmacies that rely on the sale of tobacco products. We have not found that in these hearings.

**Mr Dumulong:** No?

**Mrs Haslam:** They do not rely on tobacco if they are a pharmacy. It ranges between 5% and 10% of their sales. It's a good cash flow product at the front of the store when they pay for cigarettes versus when they come into the store and they're a turnover. But we've also had many come in and say that they've survived without it. So I would question your idea that they rely, because that's not what we're hearing. But I want to ask you specifically about a couple of things.

You talk about "authorities...take control of the dis-

tribution of tobacco products." Do you not agree that governments should be taking control of this product?

**Mr Dumulong:** I totally disagree with that.

1350

**Mrs Haslam:** Okay. On the minimum age requirement, are you aware that we are not the only province? There's New Brunswick, Nova Scotia, British Columbia, Newfoundland and Ontario, so out of the provinces, you're looking at five. You're looking at half the provinces with the same age. The reason we brought it in in Ontario as this suggestion was because of an age-of-majority card and proper identification. It's not a matter per se of only the age. We could have made it 20; we could have made it 21. What we do feel is important is that we have to have some viable and approved sense of identification. In Ontario, with an age-of-majority card, that would coincide with the age of 19. So when you talk about "18 to 19 will create confusion," I disagree again because half the provinces in Canada are at 19.

It was interesting that you brought that one forth. It was very similar to the previous legal presentation from the tobacco manufacturing council and it was a very interesting legal type of presentation.

My last question is around organized-crime-led tobacco.

**Mr Dumulong:** I'm sorry?

**Mrs Haslam:** Organized-crime-led tobacco. What makes you say that by reducing the number—it's not what you're saying; it's that you've included its being "offered by organized-crime-led tobacco contraband." I'd like to know where you got your statistics around the organized crime in the operation of tobacco contraband.

**Mr Dumulong:** They control it. I think it's a known fact.

**Mrs Haslam:** That's what I'm asking. Where did you get your information?

**Mr Dumulong:** Just to give you an example why organized crime is involved in that, you can buy a semi-trailer of cigarettes in Indian reserves in the States, if I may, at \$612,000 Canadian, resell it at \$27 with their well-organized distribution network in Canada. That means \$2.025 million minus that \$612,000. That's \$1.4 million profit. There's 24 passing—

**Mrs Haslam:** That's my question. You're talking about organized crime. Are you saying that the bands which are selling tobacco are organized-crime-led?

**Mr Dumulong:** I never talk about the Indians.

**Mrs Haslam:** That's what I'm asking. Where did you get your information about organized crime?

**Mr Dumulong:** I guess we should not put everybody in the same boat here. There are some elements of native people who are involved in that. We all know that; it's a known fact. But this being said, I don't think we should put everyone in the same basket, saying that all Indians are in that same boat and that all Indians are corrupted by organized crime. But we all know—

**Mrs Haslam:** So you see a major growth in the contraband as coming from organized crime?

**Mr Dumulong:** They are controlling the—



**Mrs Haslam:** And where did you get that idea?

**Mr Jim Wilson:** The RCMP commissioner's letter to the PM.

**Mrs Haslam:** That's what I'm asking.

**Mr Jim Wilson:** Inkster's letter to the Prime Minister states that.

**Mr Dumulong:** We always hear from the police authorities, and it's well documented in the *Sûreté du Québec* and the OPP that it is led by organized crime. I guess if you read the newspaper as much as I do, I don't have to go into that. We know that it's organized crime.

**The Chair:** Thank you very much for coming to the committee this afternoon. We appreciate it.

#### NON-SMOKERS FOR CLEAN AIR

**Dr Ed Napke:** I'm Dr Ed Napke and I've been involved with Non-Smokers for Clean Air for some 20-odd years. Our association receives no grants or benefits other than the fees we have from members. Most of the members have had some illnesses from smoke, secondary or otherwise.

**Ms Jinny Slyfield:** I'm Jinny Slyfield, president of Non-Smokers for Clean Air.

**Dr Napke:** The small, typed article is what I'm reading from. It says, "Without Prejudice," and it was written by Dorothy Vallillee, who is a senior in one of the seniors' residences here in town. Several other seniors were supposed to come, but feeling intimidated, have not shown up. They may by 2:30, but up to now they haven't. So I'll just read this. I have not edited it; it's as Dorothy Vallillee has written it.

Before I go further, there is a perspective I'd like to bring out, which is that "tobacco smoke" is a misnomer. You have to picture it as a poison gas with known toxic effects both for normal people and for people who are sensitive to smoke. So there are two kinds of responses to smoke: normal people, who can tolerate it except for the smell and things of that nature, and then there are people who are sensitive or hyper-sensitive, which will bring on a reaction as soon as they're in the vicinity of smoke.

The other thing that has to be kept in mind is that although the perpetrator of smoke may have left the room, the gas is still there. Think of this as a poison gas, and though the perpetrator has gone, the smoke is still there until something filters it out, if at all.

"Ladies and gentlemen:

"For the sick, infirm and elderly of senior citizen residences in the city of Ottawa, this presentation to you is a matter of life and death.

"We are here on behalf of some residents to present to you their issues on the status of their declining health. They are confident their health would improve if secondhand smoke were eliminated from these buildings.

"They tell us that their quality of life was not taken into consideration when you were establishing the current smoking regulations.

"We are more aware now of the carcinogenic dangers of secondhand smoke in our environment. The 'fatal' statistics were given to us by the provincial and federal

governments (departments of health) who have spent millions, perhaps billions, of our tax money on tobacco research. Were their studies in vain? Their suggestions and recommendations have gone unheeded by another ministry, Housing, who govern and regulate the buildings in which we live and breathe our air—for better or for worse! Are these ministries cooperating with one another or working against one another?

"In our twilight years, the message we are getting is, 'Nobody really cares about our health problems or our quality of life.' Something is radically wrong. We plead with all of you to listen to and to help us—time is not on our side.

"Attendance at some activities has dropped off from a once active social life. We can no longer tolerate the leftover secondhand smoke which has contaminated our games room, lounge and permeated into our kitchen. The smoke odours have penetrated our fabric-covered furniture and the carpets.

"We must not forget the residents who are on continuous oxygen. They cannot walk freely about their own home just in case someone has 'lit up'; thus, we the majority of residents must remain isolated in our units. You are all aware of the psychological effects of isolation which in our case is forced because of secondhand smoke. Could this be elder abuse? Criteria designated by Health and Welfare state that this is so. If a detailed medication survey was taken in this building, the realization of medication for lung, arteriosclerotic heart disease, asthma etc would be outstanding to all of you. So why add fuel to the fire? An ounce of prevention is still worth a pound of cure.

#### 1400

"Turn this old, old saying into cash and the amount is enormous. Therefore, your present regulations on secondhand smoke is definitely contributing to the escalation of our health care system and affecting our quality of life.

"There is no doubt in our minds that the cost of this medication could be reduced if secondhand smoke could be controlled by the Ministry of Housing.

"We came here to seek your help when we made the decision that we do care enough about our suffering neighbours to reach out for help on their behalf. Timidity and vulnerability prevent them from approaching you or anyone else. It has not been easy for us to be involved, since this smoking issue has created notable disunity in our buildings.

"The Ministry of Housing has been aware of this disunity, hostility, animosity, antipathy and defiance of suggestions issued by housing authorities. It is very, very sad to experience the feelings of ambivalence and apathy which have overtaken residents this past year—mostly attributed to the smoking regulations. They cannot understand the justification of this issue dragging on and on. This attitude does not give them any hope that one day they may enjoy the same freedom you have in your workplaces. We all have rights, that is true, but no one has a right to make others ill at any time, or anywhere, or at any expense.

"Please make our building safer by the bottom line of this issue: No smoking anywhere except in your unit.

"We thank you for this opportunity to speak with you. We are willing to discuss this issue any time and anywhere at your convenience. It is a matter of life and death. Please listen to our plea. Thank you.

"Sincerely yours,

"Dorothy Vallillee,

"On behalf of some residents of seniors' housing in the province of Ontario. Without prejudice."

**Ms Styfield:** Non-Smokers for Clean Air is a group of volunteers who are either directly affected by tobacco smoke or very much aware of the danger of environmental tobacco smoke for non-smokers. We have several physicians in our group.

First of all, we want to congratulate the government for its recognition of the need for protection from tobacco use, and we welcome the opportunity to speak to you today. Our presentation will be limited to one topic, that of the serious need for legislation to regulate smoking in common areas of apartment buildings, especially those occupied by senior citizens. Apparently, no level of government now has the authority to provide this protection. This is a very serious health and lifestyle issue, and we urge the Minister of Health to amend Bill 119 to include this badly needed legislation.

We became involved with the issue of smoking in seniors' buildings because seniors asked us for help. These were people who had made a simple request: "Please establish and enforce regulations against smoking in common areas of our buildings." They did this through their tenants' association. As you heard, they encountered amazing resentment and many of their initial supporters backed away through fear of personal reprisals.

Most of us had believed that seniors were either covered by existing legislation or we would be concerned enough about the health of other seniors so that they would not be subjected to environmental tobacco smoke. It seems that seniors are the one large segment of our population which has been totally ignored, this although seniors suffer more respiratory distress and heart trouble than the general population.

The argument that smoking seniors deserve special exemption from smoking legislation is blatantly unfair to non-smoking seniors. These buildings are home to all. The lounges are for the use of all. If they're filled with tobacco smoke they contain at least 43 substances known to cause cancer in humans and animals.

We asked for help from the Ottawa-Carleton Council on Smoking and Health, of which we are a member, and the regional health department. Together with representatives from several seniors' buildings, we approached the Ottawa-Carleton Regional Housing Authority to ask for a policy. We asked that all lounges be designated non-smoking so that all residents can enjoy their use.

Housing takes the view that all such issues must be settled by tenants at tenants' meetings. While this is perfect in theory, the reality is that the sick and the frail elderly cannot attend these meetings because of tobacco smoke. Also, many tenants are simply unaware of the

danger of environmental tobacco smoke.

The additional problem is fear. There have been several incidents of physical and verbal abuse, vandalism and racial insults, all directed at those tenants who requested non-smoking lounges. Many tenants who originally signed petitions later asked that their names be removed for fear of retribution. Many seniors are now prisoners in their own apartments.

Personal tolerance levels vary greatly. My own health and lifestyle have been affected by exposure to environmental tobacco smoke, so now I experience physical symptoms after a very short time.

At the request of residents I visited lounges in two buildings in Ottawa. In the first one, no one was smoking because the exercise class was in session. Incredibly, even this small concession, to prohibit smoking during an exercise class, had to be fought for. After two minutes in each lounge I experienced allergic symptoms, just as many tenants do. My eyes watered and began to sting, my nose stuffed up and I began to cough. I had to leave before I developed a headache.

There is no way I could have attended an exercise class in those rooms. However, the seniors concerned enough about their health to exercise were constantly exposed to this environmental tobacco smoke residue. Many seniors who suffer from asthma and heart disease simply cannot attend exercise classes or any social, religious or administrative function in these lounges.

It was shortly after my visit that carbon monoxide tests were performed and levels were found to be "low." Air testing is absolutely useless if it measures only carbon monoxide. There are 43 other death-dealing substances. Fans and air cleaners do not eliminate these particles. A quotation from the Heart and Stroke Foundation states, "Shared ventilation systems would require the force of a small gale, about 226 air changes per hour, to effectively eliminate the environmental tobacco smoke from a typical indoor work area where smoking is permitted."

Voluntary compliance does not work. It did not work in the workplace, when non-smoking employees were expected to speak up against a roomful of smokers, it did not work in public places, public transportation or retail stores, and it does not work in seniors' buildings.

Smoking is a health issue. It is not a question of numbers of smokers versus non-smokers in a particular area. Health professionals all agree that all non-smokers must be protected. At the moment, the residents of seniors' buildings are not.

We support those seniors who have had the courage to continue in their efforts to protect themselves from tobacco smoke. We advocate that smoking be prohibited immediately in all common areas in seniors' apartment buildings. It is our hope that eventually several floors in every apartment building will be declared non-smoking and that several apartment buildings in each city will be designated totally smoke-free.

This is a health issue. Non-smokers need the protection of legislation. We strongly urge this committee to recommend that it be included as part of Bill 119.



**The Chair:** Thank you for the presentation as well as the letter. I think this issue may have been raised before but certainly not in as directly focused a way and as specifically. We'll begin the questioning with Ms O'Neill.

**Mrs O'Neill:** We did have this brought to us, actually, by an actual resident in Sudbury, a very poignant presentation, a very personal one, and certainly in my role as a member of provincial parliament, I've had quite a few representations from residents.

The bottom line is that I think we need to get other ministries involved in Bill 119. Have you, through your organization, contacted the Honourable Elaine Ziemba, who is the Minister of Citizenship and is responsible for seniors' issues?

**Ms Slyfield:** We have not contacted that minister but we have contacted the Minister of Housing.

**Mrs O'Neill:** What kind of a response have you received from the Minister of Housing?

**Ms Slyfield:** Not very sympathetic.

**Mrs O'Neill:** At the moment you're thinking only of the housing that is provided by the province, that is, the non-profit seniors' residences that fall under the various municipalities, and in cooperation with the municipalities, the housing authorities?

**Ms Slyfield:** We have to start somewhere and we've had the most representation from those. But we also have had calls from people who are living in other apartment buildings.

**Mrs O'Neill:** Do you have the support of the municipal officials?

**Ms Slyfield:** Yes, the regional health committee.

**Mrs O'Neill:** Would they be making representations on your behalf to these various ministries?

**Ms Slyfield:** Yes, we are working with them and they are going ahead with some plans.

**Mrs O'Neill:** I would strongly suggest that you write to both of those ministers—

**Ms Slyfield:** All right.

**Mrs O'Neill:** —and I think it would be wonderful if you could have a letter from RMOC that also accompanied and had the same purpose as your letter—

**Ms Slyfield:** All right.

**Mrs O'Neill:** —because this is not going to fit into Bill 119, although it is an issue that we have had brought before us on more than one occasion in more than one city. I think it's an issue that does demand attention.

**Ms Slyfield:** Thank you very much for your help.

**Mr Sterling:** Actually, it doesn't surprise me that the government is not very sympathetic to what you want. It seems that this government and the previous Liberal government as well, I might add, have continued to restrict the rights of people to pick the kind of accommodation they want to live in. You no longer can have an apartment for seniors only, people who don't want to live in an apartment where there are children. You can't go to an apartment that doesn't have pets. The whole concept of allowing people the right to choose their community, be it a building, a floor, I don't think is acceptable to this

government in terms of its philosophy.

**Ms Slyfield:** What can we do about it?

**Mr Sterling:** Change the government.

**Mrs Haslam:** I think that does call for a comment, because we've all tried to be so non-partisan. Welcome to the committee, Mr Sterling.

I think there are choices out there where you can live. It's just that what he's talking about is government-funded housing and they open it to everyone. They are not exclusive; they are inclusive.

I understand the concerns of some seniors who have a concern over this, but I think there are two ways of looking at that. I think that as a government we look at the inclusivity of the support of people who live in government supported or subsidized housing, looking at it being more inclusive than excluding people from that subsidy. I'll just throw that out.

We can't really discuss this specific issue, because as Ms O'Neill has indicated, it does fall under Housing. It is a difficult situation to deal with when we're dealing with common areas, and maybe the municipality would have to look at a type of bylaw. I'd ask the PA to maybe do a clarification on that issue about municipality versus this legislation, looking at that type of thing.

I'd like to go to one quick question. Would there be an addition to some of the places that we are looking at in banning smoking that you, representing possibly a seniors population, would like to see added to what is already present in Bill 119?

**Ms Slyfield:** The main thing that we would like to see is the addition of their homes, the places where they live, because that's where they spend most of their time.

**Mrs Haslam:** Are you asking that the bill say that in an apartment building we then legislate that a common area in every apartment building be smoke-free?

**Ms Slyfield:** I'd like to see that very much.

**Mr O'Connor:** I appreciate your comments and your very well-written presentation. To try to get out of the partisan atmosphere that somehow we've gone into, I could see why the Minister of Housing would suggest that this should be dealt with locally, because the Minister of Housing is trying to really start to create a dialogue in different housing atmospheres, especially in buildings, that it's planning together, working together with everybody. I can see the unique problems that you're pointing out here, and I really do appreciate that.

I have a question for you and then I'll make a commitment for you, as I have on another occasion. Ottawa has got some of the best municipal bylaws, I think, in the country. I don't believe there is anywhere in a municipal bylaw, right across the country, that what you're asking to be included is included. I don't know whether you might know what the reason is; maybe that's something I'm going to have to look into.

Just before you answer that, what I have done in another, more specific area that was pointed out to us as a problem is that I've undertaken to write to the Minister of Culture, Tourism and Recreation. In this case, I'll undertake on your behalf to write to both the Minister of

Citizenship and minister responsible for seniors' issues and the Minister of Housing to try to see what we can work out for this certain issue.

You've obviously worked hard with the folks from the Ottawa council, and I just wondered if you could maybe help us understand why that might not have been dealt with there, knowing that it's some of the best municipal bylaw legislation in the country.

**Mr Jim Wilson:** You're passing the buck.

**Mr O'Connor:** I'm not passing the buck here.

**Mr Jim Wilson:** Sure you are. Your legislation allows you to do what these people want. What are you going to do, is all I want to know.

**The Chair:** Order. The question has been asked. Let the witnesses reply.

**Ms Slyfield:** This cannot be dealt with by a municipal government. It has to be dealt with at the provincial level. One avenue that apparently is open is to ask the province for enabling legislation, which apparently takes two years. Some of these seniors aren't going to last that long. It might be in place when we're all ready to go into the seniors homes; we don't know.

It has to come through the province, and if this region asks for it and we get it within two, three or four years, then it applies to only this region. If Sudbury wants it, Sudbury has to apply. That's why we're asking the province to look at it for the whole province.

**Mr O'Connor:** I'll undertake to look into the possibility of putting this in there and contact those two other ministries. In a non-partisan atmosphere, as we have here, I want to thank the Tories and the Liberals for all the work they've done on this in the past, and the action that the federal Liberals have done as well.

1420

**The Chair:** Did you wish to make a comment?

**Dr Napke:** Let's get above politics. It's very hard to go above politics. Yes, it's very hard, but I will take the balloon and go up much higher.

This is a matter of health in a group of people who in themselves find that they have been dispossessed of the rights and quality of life, and they are not aggressive people. It takes an awful lot of courage. We're younger; well, some of us are younger. I belong to the category. The vast majority, and particularly a large number of women, are timid. With an aggressive individual lighting up a cigarette and saying, "These are our rights," they back off, and then they can go back into their rooms. So they are isolated. They are living out there but they can't participate in the functions of the place.

The others say, "Well, you can come down." They don't understand that there are some people who within minutes become ill. They don't understand that because it is not the common norm. There are people who become ill. They think they fake it or something but it's not true.

This is the dilemma. They cannot speak up at these meetings for their shared rights, because everybody has rights. Smoking is legal, so there's a right to smoke, but it's where. The problem, as I said before, is that this is a gas and after you leave a room, the gas remains. If you

come in, it's going to cost a fortune to try and get that out and there's no need. You should have an area, just like in the workplace, where there is no smoking. The smoker can come in and participate, the non-smoker can come in and participate, and then they can take their smoking to wherever else they want to do it, in their own units.

These people, seniors, which we will all hopefully become, we change in our aggressiveness and our demand for rights, and if you already have an illness, chest or otherwise, it makes it even worse, and why fight it? It's a different ball of wax defending their rights. Any health regulation dealing with smoke or otherwise should take into consideration the specific group called seniors.

**The Chair:** You have both made that issue very clear to the committee and I know it is very frustrating at times when it would appear a solution is possible and yet it doesn't come to hand. Your testimony today has certainly made everyone here very much aware of it and I think we all recognize we've got to find a way to solve it in a way that isn't going to take three or four years. Thank you both for coming to the committee.

**Dr Napke:** Can I add just one point on how serious this is, smokers versus non-smokers, in these buildings? I know of one person, and there are others, who had to leave the place and move into another spot. We had people who said they signed a petition and then asked for their names to be taken off because of real or imaginary or what have you feelings.

**The Chair:** Thank you for coming and thank Mrs Vallillee for her letter as well.

TOM JOHNSON

**The Chair:** I call Mr Tom Johnson from the Canadian Cancer Society. Good afternoon, Mr Johnson.

**Mr Tom Johnson:** Let me say that I'm very nervous.

**The Chair:** Don't be nervous.

**Mr Tom Johnson:** I'm not sure who the good guys and the bad guys are, who should be wearing white, who should be wearing black.

**The Chair:** There are no bad guys in this room. This is just a group of people who have been sitting for a long time and every now and then they get a little tired, but they're actually good folks. So just pretend you're sitting down and having a discussion with your colleagues.

**Mr Tom Johnson:** My role in life is marketing. I'm a marketing consultant. I first want to apologize for the copies. My photocopier broke down, so consequently you've got streaks on your paper. I hope to use my experience to address at least one or two of the issues later on.

My role in life as it relates to this committee is that I work for the Canadian Cancer Society as a volunteer, as does my wife. My wife does volunteer rides for cancer patients. She administers that. I'm also part of the local committee here on the Ottawa-Carleton Council on Smoking and Health, and I've been involved in a couple of bylaws in the area.

I live in Kanata and about two years ago I got involved in the generation of a smoking bylaw. Kanata,



at the time, didn't have a bylaw, Ottawa had a pretty decent one and Nepean was just about to release its recent bylaw. So what I'm hoping to bring today is a perspective on what I had to go through to get that through, the kind of obstacles I saw, and at the end of the day when the bylaw was successful, what the results were.

This is a much more complicated subject area than I ever imagined when I first looked at the issues you people would be dealing with, so I tried to focus in on one area that I could bring a specific focus to, and that's why I'm going to talk about my experience with this bylaw. What I find interesting is that you've seen the same kinds of things that I saw when I was doing this in microcosm in Kanata, which are the excuses, the reasons for why we can't do a strong bylaw. All of them are valid, all of them have support, but at the end of the day, they all disappear once the law's in place.

I went through my notes when I did Kanata's bylaw and I've just taken out some of the statements that came out of a document from the bylaw office here in Kanata. One is: "Enforceability of such a bylaw is a problem, is an issue. Concerns stem from the politically active nature of the general population of Kanata as an excuse for why we shouldn't put in this kind of bylaw." Another one, "So restrictive as to cause the source of someone's livelihood to unnecessarily suffer." Has anybody heard that before?

#### *Interjections.*

**Mr Tom Johnson:** Okay. "The regulation of bus shelters would need to be done across the region and by sheer numbers would be unwieldy," was another reason we shouldn't put in aspects of the bylaw. "The major centres in the region would be inconsistent in their smoking regulations," was an excuse for not making it a stronger bylaw. A delaying tactic was, "Petition the regional municipality of Ottawa-Carleton to make application on behalf of the regional municipalities."

We went through three heavy-duty council meetings to put some teeth into our bylaw. When drafting the bylaw for Kanata, we built on what we'd seen in Ottawa and what we'd seen in Nepean to come up with the best bylaw we could possibly get for Kanata. At the end of the day, after all the noise and the negative barriers that were put in front of us in getting this bylaw in place, the bylaw actually had three parts: a public part, a workplace part and a vending machine part.

We were successful in getting the public part into place, and we got nothing but positive feedback from the press. Enforceability of the bylaw was not an issue at all. All the issues that had been brought up beforehand disappeared once the law was in place.

Ultimately, the thing I drew out as the most positive press piece that I got here locally in Ottawa was that we have a "Cheers and Jeers" column. Kanata is well-known for its obnoxious bylaws, and under the "Cheers and Jeers," the thumbs-up was that we'd finally put in a bylaw that was progressive, that changed the world.

That's part of why I'm here and I believe why a number of you people have gone into politics: We believe

we can change our corner of the universe. I wanted to change my corner of the universe, and part of that was starting in the city and looking at what I could do to get something in place.

We talk about the voluntary part of the local community doing things. We looked at the local restaurants to see what the voluntary rate of no-smoking areas was in restaurants in Kanata, and it was 14% at the time. We now have a bylaw in place that starts at 50% and is a progressive bylaw that over a number of years goes up to 70%. At the end of the day, the restaurant people loved the bylaw, because among other things I personally can look like the bad guy and they can be the good guy implementing this bylaw. That can be an effective tool for you when you're looking at implementing this.

#### **1430**

There are a lot of us out there who have put an awful lot of energy into this process of researching the area, finding out what the problem is with smoking and health and then presenting this and pushing it and pushing it and pushing it. One of the biggest problems we've found in doing the municipal thing is that there's just an incredible amount of bureaucracy to get this done.

If I look at Kanata as a specific example, it took a year from the day the council decided that there should be a bylaw before we showed up. Nothing had been done. We presented a bylaw and it took three heavy-duty council meetings and then it got implemented about four or five months later.

We still don't have a workplace bylaw. The reason we don't have a workplace bylaw is because we need enabling legislation.

We looked at how we could get enabling legislation for that. To ask our solicitors to do that and do the presentation would've been an expensive proposition when we're trying to keep a zero growth in taxes, so we passed it on to the regional municipality here which felt it could do it region-wide instead of just on an individual municipality basis. It's been about a year since I requested that from the regional municipality. I've asked just about every couple of months: Where are we at?

There are all sorts of reasons and good reasons why the solicitor hasn't done it yet and so on, but at the end of the day, it didn't get done. Each municipality has to do this to get its workplace legislation in. Our latest estimate, now that it's actually been passed on from the regional government to the province, is that if we're looking at about a two-year delay before this actually gets implemented, before it comes up in front of you people to give us enabling legislation here, obviously that's not the good way to do it. In this particular case, timeliness is just so important.

We were talking about statistics the other day and I was talking to Dr Ellis of the regional health unit here and he looked at how many people die in this region from smoke-related diseases. I tried to bring it back home to your particular riding. If I look at the ridings in this area, in Dalton's riding, there are going to be 100 people who die this year from smoke-related diseases who we have no doubt about. On top of that, there are the other

people who are the marginals. I have a neighbour who died last year of a lung-related cancer. Lung cancer is really strongly related to smoking. It's virtually a causal relationship now. She wasn't a smoker; her husband was. She just left a one-year-old baby behind. This is a timely thing. This has to be done now, not years from now.

I know the workplace bylaw isn't on the books now, but I strongly ask you, if you don't put a bylaw in or a law in to cover the whole area, then do something about giving us the ability to do it. Give us blanket enabling legislation or something. Give us the tools and we'll do it, but it's got to be done now. People are dying today.

By the way, one of the major benefits of putting these bylaws in in a progressive stage was—what we saw was that Ottawa had a nice good bylaw that it did an awful lot of missionary work on and Nepean built on that and Kanata built on that.

I recently did a presentation to the West Carleton council and when I told them that our version of the bylaw was progressive from 50% to 70%, she asked me, "What are the statistics in terms of smokers and non-smokers?" In the Ottawa region, 23% are smokers. So she asked me, "Why would we want to do 50%?" It's a pretty classical situation we get in terms of bargaining and so on. The reason we did that was to accommodate the smokers. I just don't believe that any more. West Carleton is looking for either 80% or 100% in its bylaw that's coming up shortly. We've got to stop being in this role of always accommodating the smoker. It's a very small percentage of the population now. The big percentage of the population are people like me who want to go to the restaurants.

One of my neighbours is the mayor of Kanata. She doesn't go to any of the local restaurants because she has asthma. She can't go there because of the smoking, period; it doesn't matter whether it's 10% or 15% or 50%, like we currently have.

What do we do about this? When I looked at what you people had done over the last few weeks in your work, I finally came down to, I think, a common denominator. You can call it good guys, bad guys. There's a group of us looking at the health aspects and there's a group looking at the profit aspects; I would go one step further and say the greed aspect. If we look at the white suits and black suits, it's pretty easy to see which has got the higher ideals.

If I look in terms of accommodating the business aspects of smoking—you've seen all these statistics and I'm not here to present the statistics because the cancer society has already given you those in terms of health aspects; it has given you the statistics in terms of what really happens to pharmacies—we don't have to believe any more that the pharmacies are going to go bankrupt next week if there's a law like this in place. It's just not going to happen. I think you've got enough anecdotal information to support that. We haven't seen a single case where the pharmacies have voluntarily stopped selling cigarettes and it has affected their business in a way that they haven't recouped it in two years. It just hasn't happened. You've got Imasco doing presentations to you suggesting that their profit is the main reason we

should accommodate the pharmacies.

When I look at the three areas that I believe are important in terms of reducing access to cigarettes or the promotion of cigarettes, I've come up with my version of the universe, which is the access to cigarettes, the allure of cigarettes and the social aspect. I have a nine-year-old son and a seven-year-old daughter and I want to enhance their environment in the future such that they don't end up trying tobacco products. You've already seen cases where children have gone into the stores to buy cigarettes. We've got to limit the access to these children. The pharmacies are a good start.

I personally think you have to go one step farther and look at licensing tobacco. When we looked at licensing vending machines in Kanata, we used Nepean as an example. Nepean considered its licensing program a cash cow. I believe firmly that if you did look at the licensing issue, it would be self-paying. It's not going to be a cash drain to you and it will definitely make these people think twice about making cigarettes accessible to children. The pharmacies represent 25% of the sale of tobacco, as I understand it.

1440

On the allure side, I'm going to give you a quick example of the allure of the cigarette packaging. I'm from the marketing side of the planet. The packages are designed to be appealing to kids. Last week, I was at Mont Cascades skiing and I was just about to get on the chair-lift, and there were two young ladies in front of me and a young man who was operating the T-bar. He took a package of cigarettes that was behind him on a shelf and put them in a spot over near the apparatus. It seemed clear to me he was displaying—he wasn't going to open the package and start to light the cigarette; he was moving it to impress the ladies with this package.

It struck me that there's the problem. In my business, we were just looking at marketing a product and as one of the ways of marketing that product, we were going to do mouse pads, because the mouse pads advertising that company are always visible on that guy's desk top. What a bright way of marketing. I'll tell you that the cigarettes are exactly the same thing. You've got to change the packaging of the cigarettes to stop their advertising. That's the way they advertise.

One other point in terms of the three areas that I saw in terms of reducing access or promotion of cigarettes is to reduce the social support for it. We've got to start making cigarettes dissociated with things like bingo halls, bingo parlours and bowling alleys. Two obvious ones: We've got to dissociate it from the pharmacies. You've got to separate that out. The other area: Ultimately, you've got to separate it out from eating. It shouldn't be associated with restaurants; it shouldn't be associated with grocery stores. If we do those kinds of things, we make it more of a miserable thing to find the cigarettes and associate it with just cigarettes and not with eating, not with pharmacies, not with drugs and other things.

**Mrs O'Neill:** Could you just tell us some of the public places that your bylaw covers in Kanata?

**Mr Tom Johnson:** We banned it completely from all



recreational areas—

**Mrs O'Neill:** So that's the wading pool.

**Mr Tom Johnson:** Yes—any municipal offices, anything owned by the municipality; in fact, we went one step farther and anything we rent out to other people. You can rent the facilities, but you still can't smoke in them except for—

**Mrs O'Neill:** Is there an arena involved?

**Mr Tom Johnson:** The arenas actually were before, but we included the Palladium; it's not built yet, but that's part of it as well. In the shopping malls, we restricted it to the eating areas, unfortunately, and that's a compromise. It's interesting, the press afterwards—the eating areas became the focal point for smoking and one of the local vendors was selling women's clothes nearby and this owner was a smoker. He's asked the city to do something about it because his clothes all stink of smoke.

This was another point that I haven't put in here, but in both the councils I dealt with, Kanata and West Carleton, each council had at least one smoker on the council. They were completely for a progressive law, especially as it relates to making cigarettes difficult to access for kids. I'm kind of surprised that they limited this group to not have smokers, because they're also advocates of this, believe it or not.

**Mr Dadamo:** It's become crystal clear in all this that we have to take cigarettes away from the young people and hope they won't start. Is there anything your society does with the high schools or the grade schools in this area, anything on a curriculum basis that would better instruct kids on the health hazards?

**Mr Tom Johnson:** Education doesn't work, or it works very minimally. You have to be progressive in the laws and make them strong. We've been fighting a battle recently with keeping the cigarette smoking off—we can ban it from the schools and then the teachers go out and smoke in their cars out in the parking lot. What kind of image does that give to the students? Yes, we're working heavily, but it's got to be more than just education for students, because the staff just don't support it.

**The Chair:** Thank you very much for coming before the committee this afternoon and for your presentation.

LUNG ASSOCIATION, OTTAWA-CARLETON REGION

**The Chair:** If I could next call on Mr Greg Penney of the Lung Association of Ottawa-Carleton. Mr Penney is accompanied by Trisha Chelton. Welcome to you both.

**Mr Greg Penney:** Actually, we'll start with Ms Chelton and I'll be moral support. I'll speak after.

**Ms Trisha Chelton:** My name is Trisha Chelton. I am 19 years old. I am a non-smoker and I have never, ever had a puff of any cigarette ever in my life. One of the reasons now why I don't smoke is that I have severe asthma. When I have a severe asthma attack, I have to use a machine with a mask and medications to help me breathe. These sometimes are worsened even when I'm around secondhand smoke. I get so that I'm coughing and wheezing and gasping for air and I just can't breathe.

When I used to live with my parents, I got a lot of secondhand smoke from my mom, because she smokes,

and then those symptoms would arise. After I moved out, I lived in a smoke-free environment, and now I notice that when I'm around smokers my symptoms are even worse in that my throat gets really sore and I find it hard to swallow.

I came to speak because I think I have the same right as everyone else to breathe clean air and I notice that sometimes my rights aren't enforced. Two main examples of this are that when I go into a bus shelter, say, to wait for the bus, and the sign that says "No Smoking" is clearly placed, there are still smokers who think they should smoke in the bus shelters and some who even block the area where the clean air is coming in. They look at me like I'm strange when I say, "Why don't you just look at the sign and smoke outside, please."

Another main example I have problems with is certain restaurants. There's one restaurant I go to a lot. At different times it's quite smoke-free, but other times I can't go during certain hours because I know a lot of people who will be there are smoking and I won't be able to breathe if I go there. One exception I have just found is a Tim Horton's on Bank Street. It says right out in front of it "Smoke-Free."

I like going there because there are no smokers. I even asked them a couple of days ago when I was there—it was suggested I ask them—if they've lost any business because of it, and they said the first week or so they did but now they find they've got a new set of clients, people who don't smoke. They're quite happy with that. So I would encourage all restaurants to take on their example.

Since I've told a lot of people about my asthma, especially those who smoke, I have had two really good friends of mine stop smoking completely because they were worried that they too could get something wrong with them and I've had another friend who's cut back on half of his cigarette smoking. He asked me to say that because he thinks it's an important thing too.

A main question a lot of people might ask me is whether I am biased for non-smoking because I have asthma. The answer to that is that I have only had asthma since I was 13. Before then, I still couldn't stand smoking and anything like that. Since I was yea high, about five or six, I've always been saying to my mom: "Why are you smoking? Please stop. You're going to get sick."

Since I've gone on this quest, I have also noticed a lot of problems at school with kids who smoke. I haven't mentioned this. I go to Gloucester High School, and we have a population of about 1,800 students. It's a fairly big population. So when I started asking people, "Do you smoke?" and things like that, it was very easy for me to come up with at least 40 kids who smoked because of the high population.

1450

I even thought it might be neat if I went to one of my classes with some of my questions about smoking. I went to a marketing class—I have a marketing class that I take—and I asked students who smoke there how many of them and how easy it is for them to get cigarettes on different days. I was very, very surprised and not very happy to find out that even though there's a law that

states that you have to be 18 before you can buy cigarettes, at least 95% of them can go to a convenience store and get cigarettes. I looked at them very surprised, and they said, "Oh, yeah," and they named all these convenience stores they go to and they have no problem at all in getting it.

These people seem to believe they're 18 just because they're tall or just because they're acting a certain way or dressing a certain way or wearing their hair a certain way. Some of them do ask them, "Are you 18?" but the kids say to them, "Oh, yes, I'm 18," and they don't ask for proof or anything like that. It's really easy for them to get cigarettes.

I asked one of them why they do this and they said that they really like smoking. I asked them how they got started and they said peer pressure. I asked even what age a lot of them started. Some of them, I was surprised to hear, start when they're 13 years old. That's really awful.

One of them brought up a point. They asked me to mention this, because I told them I was coming here today. One of them wonders why it is legal for them to smoke at age 16, but they have to be 18 before they can buy cigarettes. I'm a little confused by that point. They asked me to mention that, because that bothers them.

Another thing we talked about was the recent advertisements by the Ministry of Health. There is one ad they have with this young girl who is smoking in a washroom. She's got red hair and she's really pretty. It shows her starting to light up and then, by the end of her lighting up, she's old and sick and has emphysema. Everyone agreed that they liked that ad. Everyone could relate to that girl because she's like us, a teenager, and this is what could happen. So we like that ad.

But there's another ad they have where they have all these swimmers and they're going to jump into this pool that has all kinds of toxins and what not. The first time I saw it, it was really over my head. I couldn't understand why this would have anything to do with not smoking and things like that. When I asked the kids in my class about this, they said that it actually made them want to smoke when they saw this ad. They didn't understand why they'd have an advertisement that would do this to them.

I know a consideration is making more ads and trying to get more people to stop smoking this way, and I think a main point is that it's better to make it more like the first example of the girl we can all relate to who smokes and this is what happens to her, rather than a confusing ad.

Another thing I agree with is this idea of having plain packaging for cigarettes, simply because I know a lot of kids who started, not just because of the way the cigarette packaging is, but it was certainly a main consideration, just to see the different colours and things that made it look attractive to them. If we make it plain and we take away that idea, then it won't seem as interesting to them.

Another thing I agree with is totally banning vending machines for cigarettes, simply because obviously they're not always supervised, so you can't see how old the kid is when they're getting their cigarettes. That's just saying

to them, "Okay, you can't buy one maybe somewhere like a convenience store or wherever else, but just buy it in a vending machine where no one's looking and you can still get your cigarettes."

Even the people in my class disagreed with having those vending machines and agreed, maybe right away—it won't be May that they're totally nowhere at all, but at least make them in places where teenagers can't get access to them, like bars and things like that, because then at least you can watch who's getting them and who's not.

Another thing I have is that I think most pharmacies, if not all pharmacies, should ban it completely, because, I don't know, when I go into a pharmacy it's usually because I'm sick somehow, like I've got a cold or I need medicine for some reason. When I go to a pharmacy, I don't like to see something that could make me sick, because the idea of going to a pharmacy is mostly to get better, not to have something to make you sick.

There is one pharmacy I go to a lot, on Nelson Street, and it is totally smoke-free. They ban all tobacco products, and that's one of the reasons why I started going there sometimes.

I'd just like to end by saying that my idea for coming up here was to promote a smoke-free Canada. Nothing would make me happier as a teenager than to see no one ever smoke, because that makes a lot of people sick and I just don't agree with it. Thanks.

**The Chair:** Thank you for coming forward with such a personal story and viewpoint. We really appreciate that. Did you want to just add to that?

**Mr Penney:** Yes, I just have a couple of very quick comments. The biggest thing from the Lung Association point of view is that we've got to stop sending the contradictory message to our children. In response to what was said before, I think education is a very big part of our society. We don't spend all our lives in school learning nothing.

We have a Lungs are for Life program which is geared to various grades in the public school system. We work very hard with this program. At the younger grades it's used to teach the children how important the health of their lungs is to them and their environment. As we go to the older grades we're a little more blunt with what smoking does to them. That program isn't the end-all and be-all, but when those children leave that classroom and go out, they have to stop seeing the contradictory message that is out there in the public that smoking is "cool." They see the older children, the older teens, smoking. They're standing around with the packages and playing with them.

Plain packaging? Definitely. Licensing? Definitely. Statutory prohibition doesn't work. I'm in my mid-20s. I grew up through the 1980s with the alcohol before we got really strict and the drunk driving and all that. Statutory prohibition does not work, folks. We know that. We've got to enforce it properly, and the only way to make someone realize that their business is in jeopardy if they don't follow the law is to have them licensed and they can lose that part. It's self-funding. We know that.



I know it's a tough situation, but we've got to deal with these issues and quit sending the message to our children that what I see out in the public is all right but I'm being told something else by my parents or I'm being told something different in school. We've got to stop that.

**Mr McGuinty:** Thank you both for your presentation. Trisha, I appreciated your comments about the advertisements. In fact you were giving the same kind of critique we've heard elsewhere. I can't recall exactly. I agree with you. The one where they jump in the pool is rather attractive to watch, but it's abstract and the meaning doesn't come home in the same way as the other one did. I thought, with the young lady in front of the mirror. I thought that was very effective.

One of the things we've kicked around is this idea that when it comes to alcohol, you can't have alcohol in the school, and not only because it's against school rules; it's against the law. But you can have cigarettes. If you're sitting on the curb and you're 16 and the police officer comes by and you're smoking and your friend's drinking, the police officer is not going to talk to you and is not going to confiscate your cigarettes, he's not going to fine you. But he can do all of that to your friend. But we know that the damage that's caused by cigarettes far outweighs the damage that's caused by drinking and abuse of alcohol in this province.

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Shortly it's going to become illegal for you to ride your bicycle without a helmet. We're talking about only, I think, something in the neighbourhood of 100 fatalities a year in this province. But we're talking about 13,000 deaths a year. We're going to fine you if you haven't got the helmet on and we're going to fine you at 14 years old. What should we be doing with cigarettes and fines? Do you think that there's an opportunity there we're missing?

**Ms Chelton:** Yes, I think that they should be made just like the alcohol. Maybe we should set up a law that says it's totally illegal for any kid to even smoke. They should be fined as well, maybe the same as alcohol. That's a good example, because it does just as much and more damage when you smoke. One's really as bad as the other; therefore, they should probably be kept the same.

**Mrs Haslam:** Very quickly, because we are a half an hour behind, and I do appreciate the Chair allowing me this quick question, you're in marketing class. You asked them questions and you made comments on the ads. I'd like you to make a quick comment on, looking at some marketing issues, do you discuss this in class about being manipulated or used by tobacco manufacturing advertisements? If you did, would it make a difference in using that product?

**Ms Chelton:** We only discussed the cigarette thing once. I was just bringing it up because I wanted some opinions on that. We all basically just follow the same idea, that we don't agree with any smoking and we don't like anyone else to. We do agree that non-smoking associations and advertisements should use us in saying that no one should use it and this is a bad idea.

**Mrs Haslam:** Excellent point. Thank you.

**The Chair:** Thank you both very much for coming to the committee this afternoon. We really appreciate it.

NAGLA ACOURI

LORNE McEWEN

**The Chair:** I call on Ms Nagla Acouri, owner and pharmacist of the Crystal Beach Pharmacy. Welcome.

**Ms Nagla Acouri:** First of all, I wish to thank you all for giving me the chance to explain why I still carry tobacco in my store. Although I heard the previous presentations, especially the gentlemen from the cancer society saying that to be controlled they have to be eliminated from pharmacies, I can tell you one thing: In my pharmacy we never ever sell to minors.

My store is only 1,000 square feet. I'm at the back in the dispensary. I can see very easily the front cash where the tobacco is sold, and if I see anyone who looks underage, I go personally and I ask for an identification. They know now not to come to me, but that doesn't solve the problem. They're going to the convenience store next to me and they're getting it.

Hours I work in my store: I've been in this location in Crystal Beach for 12 years. I started this store from scratch to serve a community of 2,000 people who live in this area. I have always been involved in the community. When this tobacco issue came up, I passed papers to my customers and I asked them their opinion: Would they still keep coming to me and trusting me for my professional advice and the same service I give them, or would they prefer me to stop selling tobacco?

I can tell you that I got a response of 90% that this was something totally up to me and that it did not affect their relation with me as a pharmacist because they know how much I work and that I am devoted to my profession. That does not make me less professional than any other pharmacist who is not selling tobacco.

I worked seven days a week, 10 hours a day, for seven years. I hardly had holidays. After that, when they started opening the malls on Sundays, I had to close because I had no business. Thank God, now I have Sundays off. I still work six days a week, 10 hours a day. It is very tough for me to get one pharmacist and pay him \$30 an hour to replace me, to spend time with my kids. I've worked through my pregnancies to the last day.

The percentage of sales in my store—

**The Chair:** It's all right. Just take your time.

**Ms Acouri:** I'm sorry.

**The Chair:** It's all right.

**Ms Acouri:** I have two boys, 9 and 11. My third kid is my store. The percentage of sales of tobacco is 30%, prescriptions 40%, the rest over the counter. I don't smoke, none of my family smokes at all. I have come from a country where we don't sell cigarettes in drugstores, but on the other hand we do not sell all kinds of drugs in grocery stores.

I've worked in Europe, I've worked in England, I've visited Turkey, and it was the same principle: If you want medicine, you go to the pharmacy, you don't go to the grocery store. If the government has any suggestions and

would do anything to stop those big grocery chains from selling all kinds of our front counter—I can name you 100 products. It's no problem. They don't need a pharmacy for over-the-counter drugs.

I'm going to tell you a very interesting incident. One of my patients on a Sunday had her little kid who had a cough, so she walked to the grocery store, which carries all my front store and asked him if he had a cough medicine. He gave her Magnolax, which we all know is a laxative. She took it back home and, just reading the label, she didn't use it. She looked for my name in the directory book and called me at home. I said: "Don't give it to her. This is a laxative. I'll be coming to the store in about an hour or so and I'll give you the medicine."

I had another customer who was addicted to Listerine, the alcohol in Listerine. I saw the rate he was buying the Listerine. There was no way he was using it as a gargle. He had to be washing the floors with it. I talked to his mother and she told me that he is addicted, that he drinks it.

Now, if I didn't talk to this person—and I had to approach him a very special way so I didn't hurt him. I told him that this is wrong and this is harmful and everything. I took him as a friend and he told me, "If you were not so honest with me, I really can get that in K mart and Loblaw's and everywhere, you know, in the front store." I said: "I know that but I want you to promise me that for your health you're not going to buy it, not for anything. It's not good for you and it's not right what you're doing."

**1510**

What I do in my store to try to control the sale of tobacco, and what I suggest, opposite to maybe what everybody else suggests, which is, pull out the tobacco from pharmacies, give it to the grocery store, which doesn't care a bit if you are asthmatic or sick or dying—he's not going to check with you for anything and he doesn't care.

When I have a patient who's asthmatic or has any kind of illness and I see him going to the counter to buy tobacco, I leave my counter and go around and talk to him and tell him, "What's the big idea of you buying four inhalers and Theo-Dur, and this and that, and you're coming to smoke?" I said: "You wouldn't need all that if you just quit smoking. Have a strong will. I'm ready to help you. We'll start with the Nicorette gum and then you ask your doctor. If you feel comfortable, you can start lowering the amount of cigarettes you're smoking and then go to the nicotine gum, then go to the patches, and if you can't afford it, I am ready to eliminate my dispensing fee."

Would you honestly tell me, will the grocery store, a convenience store or a bar, like the young lady was saying, care who buys tobacco? I don't think so.

I'm not saying that it is good for your health, but we are in a free country. That doesn't mean that everybody can do whatever he wants. He can do whatever does not hurt society. This is the way I was brought up. I was welcomed in this country and I've always worked hard to show my appreciation of this country accepting me.

I hand out pamphlets. I have a big sign on the cigarette counter to say that you are shortening your life expectancy smoking, and if you need help, please call your pharmacist or come to the back. I'm the only one who works there, so they can't mistake me. Everybody knows me. If I'm not there, it means I'm dead. I have to be there.

How does tobacco help me in my business? I cannot lecture everybody to be perfect. Let's admit it: Everybody has a weak point. Somebody smokes and we tell him not to smoke. But he's hurting himself. You advise him. I've advised some patients and they told me: "We're tired of that. It is none of your business. We will smoke. We know it's going to kill us. But my grandfather smoked till he was 90. He never died." That's what they told me. I said, "Well, it is my duty to tell you and, of course, sir, you have the freedom of choice."

Why are you not worried about people being alcoholics, driving while they're drunk, killing other people? Drugs—I see it in the plaza, right in front of my eyes. I know who in the next building is trafficking in drugs. I called the police more than once. Do you think they did anything about it? There is no proof. I think this is a lot more harming to our society than selling tobacco in pharmacies.

On the opposite, believe me, if you restrict the sale of tobacco to pharmacies and tobacco stores, because that is their livelihood, you can't just tell them: "Go close. We're not going to let you sell tobacco." Then you would have control over it. But if you want to convince me that Loblaw's and IGA and the grocery store and the convenience store are going to worry about who's buying, they don't care. They hire kids of 16 and 17 to work for them and they go and sleep. The more sales they make the better.

For me, it is a source of income, but I'm not desperate for it. If I sell less, I'm going to buy less and so on. But the idea is, if some people want to smoke, they come into the store. I looked into the ribbon. I've been considering pulling the tobacco for four years. Believe me, I've tried everything. I put a dollar store in my store now; I have a section. The post office was in the grocery store and went bankrupt. So the community recommended my business as a responsible and solid business and the post office gave me the post office for no money.

I said, "God, thank heaven; that's going to do it." Do you know how much I make from the post office? I lose \$500. I have a full-time employee who gets paid. The employee has to be there from 10 am to 8 pm. His salary comes to \$1,000 a month. The highest commission I ever made in parcels and things, you name it, is \$132 during Christmas. I sold \$4,000 worth of stamps, which gave me a commission of \$400, plus \$132. I made \$532, minus \$1,000; I lost \$500.

But I am still keeping it because I said maybe—I took it last June—maybe it will get better, maybe I'll think of something else besides the post office. Then I can give up this tobacco. Not because my customers are bugging me—I have to tell you, they respect me and they are proud of me. One of them is here. Later on I'm going to tell you—



**The Chair:** Ms Acouri, I apologize that we have a limited amount of time. I know there are a couple of questions. We've gone over the 15 minutes, and I wonder if you could just bring your comments together.

**Ms Acouri:** Sorry, okay. What also makes me carry on selling cigarettes is all the pressure and the reductions that the government has put upon us. I have never seen in any place in the world a dignified profession like a pharmacist who has to hang his fee on the wall, \$9.49 or \$8.49 or \$11.99. I don't think this is very dignified, but anyway that's the rule. While dentists and lawyers are not asked to do that, we are asked to do that.

The government decided lately to cut our dispensing fee from \$6.46. They thought that was too much. Retroactively, you're going to get paid \$5.68. They didn't even ask us. If I dispense any over-the-counter medication for seniors, I don't get paid a dispensing fee; not only that, not even an upcharge.

I gave a senior 500 tablets of Tylenol, which cost me \$5.80: \$1 to enter it in the computer, 20 cents for a vial, and time of the pharmacist, and the government paid me \$5. That's just one example of how I'm losing money. The papers that I got from Pro Pharm lately showed that I have lost between \$400 to \$500 every quarter of the dispensing fee that the government has cut me off.

Now, the government cut off my dispensing fee; I take the tobacco out; the grocery store sells all my front store; I am losing on the post office. Could you tell me honestly, what is the solution? What can I do? What can I sell? I don't think I'm going to make a bakery in the pharmacy. That's the only thing that's not in the strip plaza. That's the next thing I might do. You never know.

I feel sorry as a pharmacist, educated, all the years I spent to study, to come now and be compared to grocery stores. Then there is the competition. We have enough competition with the big chains, the Canadian chains, never mind going and getting into our giving the pharmacy business to Loblaws, which makes the dispensing fee 99 cents, Wal-Mart from the States, Jean Coutu from Quebec. How can I compete with these people? I can't.

To show you how much I really care for my customers—before that, one second.

**The Chair:** Could this just be your last point? I'm afraid we're under—

**Ms Acouri:** Just two more minutes, please.

**The Chair:** Okay.

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**Ms Acouri:** Is tobacco a legal product or illegal? If it is a legal product, then I as a small store with 1,000 square feet should not be discriminated against, and allow K mart because he has a pharmacy here and he has his tobacco here—I can't do that; I don't have the space. So it should be fair, all the same.

The other thing is, if it's illegal and such a poisonous thing that the people think it is hazardous, why don't we be brave enough and ban the whole industry? Why don't we do that? Be honest with ourselves, ban the whole industry. Make Canada smoke-free. Then fine, no problem.

The only example I have to show you how I care about my customers is Mr Lorne McEwen, who is one of my patients. He's had problems with asthma and heart. He has been smoking for years. I've been bugging him for about five years to quit smoking—

**Mr Lorne McEwen:** Oh, more than that.

**Ms Acouri:** I sent him to doctors to do a test on his lungs and they told him he only had 20% usage of his lungs left and he still wouldn't listen, until lately he quit smoking. So there is an example. If Mr McEwen was buying his cigarettes from a bar or a convenience store, would he care if he quits or dies of emphysema or whatever? I don't think so.

Anyway, I want you to understand that I do appreciate you giving me the time. We're not bad guys, we're not bad pharmacists and we really don't think that everybody who goes and buys the tobacco from the pharmacists is getting cancer from us, that we are the reason. About six of my family have died and none them died of cancer, and a lot of my patients. Thank you very much.

**The Chair:** Thank you very much. I'm sorry, I don't mean to be a bad guy either in cutting you off, but unfortunately we face some time constraints. I think we have time for one quick question.

**Mr McEwen:** Could I say a word?

**The Chair:** I wonder if we could just pose the question and perhaps that could work into the answer. We really are awfully tight on our time. Ms Haslam.

**Mrs Haslam:** I really appreciate it, Mr Chair, and I'll be very brief.

I want to commend you for your diligence. You ask for ID, your professional attitude, the sign, the questionnaire to your people. But you're the first one who's come to this committee who says you actually leave the counter to counsel people. Most of the pharmacists who've come say, "I counsel when I'm asked." Unfortunately, there are others who don't make your effort. What we're seeing is that tobacco is a mixed message to our young people when they see it as an item in a store.

I was interested in your talk about the customer base. Your customers respect you, and it's not about the selling of tobacco. They would still come to you without the tobacco in the store, and I think that's something we have to look at.

I understand your concern about larger grocery stores versus a smaller store, and that's a fact of business. What this committee is looking at is health and the health of young people. I wondered if you would agree that we have to control the product more, and do you see the possibility of putting it into a tobacco control store versus leaving it open?

**Ms Acouri:** Well, I don't have the space.

**Mrs Haslam:** No, into like a liquor control board.

**Ms Acouri:** Yes. If you do that, that's fine. But if you take it from me and give it to the grocery store next to me—

**Mrs Haslam:** No, we don't give it. What we're asking is that anyplace with a pharmacy in it would not be allowed to sell it.

**Ms Acouri:** Well, I wouldn't have a choice. If you have the law, I have to abide by the law.

**Mrs Haslam:** That's right. Okay.

**The Chair:** Thank you very much. I'm sorry that we have the time problem, but we will have to move on.

#### OTTAWA-CARLETON HEALTH DEPARTMENT

**The Chair:** I call on the Ottawa-Carleton health department. Gentlemen, welcome to the committee. I believe we have Mr Edward Ellis and Monsieur Richard Cantin with us, c'est ça? It's Dr Ellis, I'm sorry.

**Mr Richard Cantin:** Actually, I've been demoted since the last time. I had an honorary doctorate when I was in Toronto to speak to you as the vice-president of ALOHA, the Association of Local Official Health Agencies (Ontario).

**Dr Edward Ellis:** Good afternoon. I'm one of the associate medical officers of health at the Ottawa-Carleton health department. I'm also speaking this afternoon on behalf of Dr Corriveau, who's the MOH for Renfrew and District Health Unit.

Because tobacco use reduction is one of our two department priorities, we have several staff working on the issue—protection, prevention and cessation—and included in your folders are examples of some of our educational material. Our health department is also a co-sponsor and home of the Ontario Tobacco Program Training and Consultation Centre, which is funded by the Ministry of Health.

I thank all of you for coming to Ottawa, the NDP government for introducing the bill, all parties for giving quick second reading and, in particular, the strong support all of you have given to individual sections of the bill.

Why is this bill so important to us? Well, we think it's one of the most important public health pieces of legislation that has gone to the provincial Parliament. Here in Ottawa, we have basically the equivalent of a jumbo jet crash every six months. That's how many people are dying of tobacco-related disease. We think that some of that is preventable, and this bill will go a long way to doing that. Also, because tobacco prices are falling, we think that the elements in this bill are very important to help offset that.

We fully support everything that is in the bill. However, I would like to ask seven questions, some of which relate to things that are not in the bill.

First is the issue of plain packaging. Is this the time to introduce it, or should we wait for some more research? We would say that the time has come. You've probably received information already about the Canadian Cancer Society study, which was in Ontario. That backs up studies done elsewhere in the world.

You've heard the other arguments for the advantages of plain packaging. It seems to us there are too many good reasons to delay. We have to try what shows good promise of working, and I encourage Ontario to take the lead in the world and do this. You've got 10 million people; it's a good chance to find out what happens.

Second: Are health warnings enough to post at the point of sale? We don't think they are. We would like to

see a telephone number on there, a toll-free number where people can call for information on cessation or protection or prevention.

We also think the regulations under this act should require that 25% of the space on any tobacco sponsorship advertising for the arts, fashion, sports, whatever, should be set aside for health warnings. Let's face it: This advertising is really trying to sell a brand of cigarettes, so it's only fair that it should also warn about their effects. If the province doesn't have the authority to do this, we suggest that you pressure the federal government to do that, or preferably to ban sponsorship advertising altogether.

Third: Will enforcement of this legislation be practical and affordable? Not yet. The people who are going to enforce this legislation, and by that I mean the public health inspectors, municipal bylaw enforcement officers, the police and others, need to know who retails tobacco in order to check for proper signage and to know where to monitor for underage sales.

If you think it's easy to list all the places that sell cigarettes, consider how long it would take you or me to list the over 800 retailers in the city of Ottawa alone who sell cigarettes if we had to check business by business. It seems to me to be a waste of our salaries, frankly, to be doing that.

I think there are two alternatives: one is a licensing system, or requiring tobacco distributors to provide a list of all retail points. Under the regulations section here, that could be done.

I prefer the first option of licensing, because it also raises revenue to pay for monitoring and enforcement. Ontario has a record deficit. Tax revenues are decreasing from cigarette sales. Without earmarked funds, this new act will not be enforced without affecting other vital activities.

We know locally that a retail licence fee of \$200 a year covers costs for enforcement. It will not be a financial hardship to the retailer. It represents the profits from selling one and a half packs a day.

We recommend that the province either license directly, do it through the liquor control board or request all municipalities to license, using the power they already have under the Municipal Act. They can use the licence revenue to pay for bylaw enforcement officers who could help enforce provisions of the act.

Fourth: Is the list of public places in section 9 adequate? Not yet, if we're really serious about reducing involuntary exposure to ETS by 1995.

In Ontario up to 25% of the population has a health condition such as allergies, asthma, angina or lung disease aggravated by ETS. These people aren't necessarily worried that they're going to die in 20 years from a heart attack or lung cancer, though in point of fact we do have 100 people a year in Ottawa-Carleton who are non-smokers and are dying from lung cancer and heart disease because of exposure to ETS. What's concerning people now is the fact that it bothers them when they go into the areas with the smoke. It can impede their use of public facilities.



## 1530

Then there are pregnant women. If you look at the ultrasound of a foetus, when the mother inhales ETS the lung movements are suspended for up to two hours. We don't know whether or not that is causing permanent damage, but it sure isn't comforting to see. Part of our education program is basically, "Don't smoke around a pregnant woman." Well, what about the pregnant woman who's going into a public place? She deserves some protection too.

Finally, there are thousands of Ontarians who are trying to quit. They're on the patch or they've just started the process of quitting and the last thing they need is to smell the smoke and get the temptation to light up once again.

We think that Bill 119 should, at the very least, offer people a choice. When they walk into a restaurant, which the restaurant association says we still do on the average of three times a week, at least half the seats should be non-smoking. Shopping malls should be non-smoking except for up to half of food premises seats.

Any parent with an asthmatic child, including my own, can tell you that hockey arenas, in the lobby or the crush space, are dynamite and they should be smoke-free. Bowling alleys can be 50% non-smoking. Bingos can be 30% non-smoking and they will survive. We know that because we have done it here and it has worked.

We've done it through municipal bylaws. The problem with municipal bylaws is that you've got over 800 municipal councils in this province and they're not going to act fast enough to have smoke-free public places by 1995. It'll just take too long without provincial legislation.

We have strict provincial occupational health legislation to prevent far fewer cancer deaths from uncommon toxins, so why should ETS, which is a proven carcinogen, be an exception? We ask you to please give people a choice when they're concerned about ETS and they want to avoid it.

Fifth: How can we achieve the 1995 provincial goal for smoke-free workplaces when this flagship piece of legislation is completely silent on the matter? We think the provincial government should ensure that smoking is not allowed in the workplace except in smoking lounges that are separately ventilated to the exterior. This is the case in the city of Ottawa, where it's working, but we only have it here because the city went after enabling legislation.

We recommend that the Minister of Labour introduce amendments to the Smoking in the Workplace Act this year or that the Municipal Act be amended to allow municipalities to pass workplace bylaws without having to go to Queen's Park every time for enabling legislation.

Sixth: Why do drugstores sell cigarettes? Well, you've heard this over and over. What I want to add to it is that locally it really isn't to stay in business. As of this week, 74% of our independent and small-chain pharmacies in Ottawa-Carleton do not sell cigarettes. That's 80, and that's up from 30 in 1989. Among the 37 Shoppers Drug Marts and Pharma Plus stores in the region, 36 are still

selling. We do have one Pharma Plus here in the Rideau Centre that's not selling. I commend them and I wish them every commercial success.

We think if the independents can survive without selling tobacco, then certainly the big chains can. But then, of course, the only logical reason to sell cigarettes in a drugstore is to make money. I think it's time to listen to the child who said, "If cigarettes are as bad as you say they are, the government would not allow them to be sold in drugstores."

Seventh and final: We'd love to start working on the regulations, please, the day after royal assent. They have to be written and implemented quickly to see results. Our health department offers its full assistance and support in whatever way it can in the drafting.

I thank you very much and I turn over to Monsieur Cantin.

**Mr Cantin:** Thank you, Dr Ellis. Those of you who heard me speak in Toronto, wearing my other hat as vice-president of ALOHA, remember my example of my dad who couldn't skate the length of a skating rink but can now, at 83, skate the full length of the canal. I invite you to take the full length of the canal to see how long that is. He's 83 years old today.

My points will touch more the political side of things and maybe the parental side of things. Dr Ellis has already mentioned that the workplace has to be included in this Bill 119, and the reason it has to be included is that you'll have a situation like in the regional municipality of Ottawa-Carleton with 11 municipalities. All you need is one to buck the trend and you destroy everything that everybody else is doing. You've got to have a province-wide act that does it. Enabling legislation is partially getting there, but I think the province-wide act is doing it.

There's a strong feeling, and it was expressed last week when Evelyn Gigantes received a copy of my letter addressed to Premier Rae dealing with the taxation issue: An elderly lady approached her and said: "Why do I have to stay in my bedroom in the senior citizens' apartment because I can't take the smoke when all the common areas are taken up by the smokers? Why aren't they regulated?" Maybe we need to have a regulation that'll protect the seniors in their own homes.

We feel strongly, and Ottawa-Carleton I believe is a leader in Ontario, that there should be no sale of tobacco in transit operations. I know the TTC would be hit pretty hard if we were to do that because at every entrance to the subway there's at least one smoke shop. But here in Ottawa-Carleton we put our principles in front of money, in front of profit, and we outlawed that possibility within our system. I would like to see something like that in the legislation as well.

Again, when you have multiple jurisdictions it's difficult to enact something without upsetting the applecart around here. As of Tuesday, Place d'Orléans shopping mall, which is one of our large regional malls, voluntarily went smoke-free. Seven out of 10 customer comment cards that they had received in the last six months stated very clearly: "I am disturbed by the smoke

in your hallways. I cannot take it. It's either you get rid of the smoke or you get rid of me as a customer." As of Tuesday 15 February they're smoke-free except for a small area in the food court. That's a positive step from a private individual. They don't think they're going to lose any money over this deal.

Lastly, I feel strongly that something should be done about the selling of cigarettes in schools. I know some of you are concerned about smuggling in schools. I feel there should be some legislation that in educational facilities, if the administration of the school is aware that something is happening, such as this one, it should be held accountable the same way as a company is in terms of fines.

I think it's just awful that you can walk into a cafeteria in a high school in my neighbourhood and see teachers buying cigarettes from the black market and the principal knows about it. He's been told more than once. So we need to do something about it. I know you're pressed for time. If you have any questions, we're both available.

**The Chair:** We do have some questions. I hope you'll understand that some members have a problem around a flight. So those of us who don't have that problem are going to ask you questions; those who have to get to that flight are not leaving because of anything you have said or done.

**Mr Cantin:** I realize that.

**The Chair:** Sometimes life gets that way. I just thought, to help those who are going to have to struggle through the traffic, if there is anyone who's got to go, if he or she has a question we could start, and then those of us who don't have to head off can continue. We'll start with Ms O'Neill.

**Mrs O'Neill:** This tobacco infoline is in existence, correct? You're the first person who has brought that forward as an idea. Could you tell us what happens when people call this number?

**Dr Ellis:** There is sometimes a recording at the beginning, so if you are a teenager and you want to get the Quit for Life compact-disc-type kit, which is basically the cessation kit for teenagers, you jump over to another line that tells you how to get it, because we had a blitz on that in promoting it and a lot of calls were coming in about that.

Otherwise it goes through to a public health nurse or someone else, a health promoter, who basically answers your question. The questions coming in can be "How can I stop?" or "What courses are available, group programs, self-help guides?" It could be a question about "Is smoking allowed here and there?" It can be "What can I do to organize a prevention program?" and so forth.

We run it for the whole region. It could be run for the province. It could be a 1-800 number. When the call comes in it could just automatically be fed out to a local health unit, I think.

1540

**Mrs O'Neill:** Is it heavily used, would you say?

**Dr Ellis:** Yes. It varies of course by what's happening in the media. During National Non-Smoking Week it was very heavily used. I think on Weedless Wednesday there

were several hundred calls. I don't have the exact number month by month, but we have basically two staff dedicated to it just to handle this region.

**Mrs Haslam:** One quick question: Under your tobacco-free pharmacies there are four K marts, there is a Loblaws, there is a Zellers, there is a Woolco. Does that mean they have already made the choice not to carry tobacco because they have a pharmacy on their premises?

**Mrs O'Neill:** They're leaders in Ottawa-Carleton.

**Mrs Haslam:** I don't doubt that. I just need to know if that's the case.

**Mr Cantin:** Maybe I could respond to part of that. Not only have you got that but you've got the biggest chain in Quebec that is now in Ontario. I was telling some of the other members—

**Mrs Haslam:** Jean Coutu.

**Mr Cantin:** Jean Coutu. If you look at number 23, here's a case in fact where this person was an independent dispensary, went into a chain, had no choice but to sell tobacco but refused to display it, hid it under counters. When I refused to cut the ribbon for him and told him I was no longer a customer after nine years of being a customer of his, he became very concerned. He approached the president of the chain, explained the situation and said, "Listen, I've got to have dispensation," which they gave him.

**Mrs Haslam:** "Dispensation" is an interesting word to use.

**Mr Cantin:** It was in his contract.

**Mrs Haslam:** I see there's a Coutu number 19 pharmacy selling tobacco but I do think that's very interesting that we do have stores like the K marts, like the Zellers, which have already made the choice to stick with pharmacy. I think that's great.

**Dr Ellis:** I should add that when we did our survey, if a pharmacy was independently owned, rented its own cash register but occupied the premises of the larger store, we considered it as a tobacco-free pharmacy because they were two separate businesses.

We would as a health department, however, support the proposal that either tobacco sales or pharmacy sales have to stop in a situation where there is one business nested inside the other. For our survey, because they were two separate businesses, we considered them tobacco-free.

**Mrs Haslam:** That changes it.

**Dr Ellis:** Yes, it does.

**Mr McGuinty:** Thank you both for coming in with your presentation. I really am pleased with the concept they have of providing assistance to smokers, because Bill 119 does not address problems that smokers encounter. That wasn't its intention. I think society has tacitly if not approved, at least tolerated smoking over the years. As we all know, it's highly addictive and now these people are in trouble. So I really like that idea.

One of the things we heard up in Sudbury, I think it was, the school principal came in to speak with us. I spoke with him outside after in the corridor and he said he found it rather perverse at this school that there had



been a smoking cessation program offered on the school premises for teachers but not for students. They developed their own program, offered during school hours, for smoking students. He maintained that an important component in that program was to get the smoking students involved in setting it up.

I'm just wondering if that's something you'd like to comment on, and it's something that we might be able to do further.

**Dr Ellis:** I think it's very important. The Ontario Health Survey showed that half of teenagers who smoke have tried to quit in the last year. The problem is that most smokers have to try four or five times before they're finally successful. We have run a number of stop-smoking programs in local high schools, quit-and-win contests. You name it, we've tried it, and we have plans to do even more.

You basically need a school board that says: "This is important. We're willing to take class time for it." You need teachers and principals who think it's important. It helps to have ex-smokers come in who have a good rapport with the kids to work with the teacher doing it. One of the things we would hope to do locally in the future is to have money available for an honorarium to the people who come in and work with the teachers and so forth to run these classes.

The most successful one I've ever read about is where a shop teacher and the students at a local high school decided they were going to do it together. The one-year cessation rate was 60%, 70%, which is phenomenal, because they idolized this guy and he had stopped and they were going to do it.

**The Chair:** That, I think, is one of the things that's been troubling as we've gone around listening to testimony from some of the young people who have said in effect that education hasn't had much impact, and the example that Dalton mentions that came up in Sudbury: trying to find, from the experience of educators and people such as yourselves in the various health units, what reaches young people. How do you reach them with a program that will have an impact? I think what you've just said is very instructive in that regard.

Just as a last question, have you found there's a barrier that you hit in terms of reaching young people? Is there an age where you're sort of saying, look, if we have to deal with, I don't know, a 17- or 18-year-old who's been smoking for three or four years, you just can't get through, that if they're going to stop, that will come later through other things? What can you tell us about that problem?

**Dr Ellis:** Well, virtually every teenager who starts to smoke figures: "I'm not going to become addicted. I can stop whenever I want to." They know they're not going to drop dead from lung cancer and probably not from a heart attack in the next few years. Then when they decide to stop, and usually it's because the price is out of hand or something else is happening in their life, they find it's difficult. If they're really motivated to stop at that point, and especially if they've tried once or twice before, then it's obviously easier to get them into a group or whatever.

If they enjoy it and if they're not under a lot of pressure to stop, then I think they're probably going to continue until they either get in a workplace where they realize they just can't go two hours without a cigarette so they might as well stop—a lot of people have done that.

That's one of the major advantages of workplace legislation, besides the protection from ETS. We saw that in the federal government: They went from a 29% smoking rate to 24% in one year flat just because for a lot of people thinking, "I should stop, I should stop," suddenly this became a reason to do it: "I can't go two hours between breaks."

But getting back to the youth, unless something comes up, it seems like it's not until they're in their 30s or 40s and they start to come to grips with their own mortality and, "It's time for me to get my body in order." So we see that with the adult programs there's a real crush in the 30s and 40s coming in.

**Mrs Haslam:** I just had a suggestion. We just had a presentation from Nagla Acouri and the Crystal Beach Pharmacy saying, "My customers are loyal to me." Obviously she was a dedicated pharmacist who left her pharmacist area to go and counsel her people, and even though at 30% of her sales she said, "I won't lose cigarettes, because my customers are loyal to me and I'm a good pharmacist," what you should be using her for is going out and talking to other pharmacists and saying, "This is the job we do as pharmacists." What a spokesperson she would be for the dedication that pharmacists need in their positions.

**Mr Cantin:** Yet—

**Mrs Haslam:** Yet she has tobacco.

**Mr Cantin:** She still sells cigarettes to the person she gives medication to for asthma. I find that a little hard to take.

**Mrs Haslam:** Yes, but she also said that 90% of her people were more loyal to her than to the tobacco sales that she offered.

**Mr Cantin:** Well, if that were the case, I would submit the case of one Jean Coutu pharmacist who quit the sale of tobacco and tripled his sales in two years.

**Mrs Haslam:** Good idea.

**Mr Cantin:** I'd like to make a final comment, if I may, Mr Chairman, because I forgot to mention it. I heard the tobacco council this morning, Mr Parker I think it was, make a suggestion that it's wrong to tax people because they've got a different lifestyle. He was saying, should we tax the automobile driver more than the person who uses the public transit because they're doing things? Well, they are taxed. They pay more insurance. They pay more taxes through the use of fuel.

Life insurance companies certainly realize that the life expectancy of a smoker is shorter, so the premiums are higher and the house insurance for a non-smoker is a lot lower as well. So yes, there are people other than governments who do tax other lifestyles or benefit people who don't abuse it themselves.

**The Chair:** Thank you. Mr McGuinty, you had a final question?

**Mr McGuinty:** Yes. I hadn't asked it before, and I'd heard some talk about this, so I want to get confirmation, Dr Ellis. What kind of recovery does a smoker have? Can they see a complete physiological recovery, or do we get to the point of diminishing returns, like if you smoke for 10 years you get 80% recovery for 20 years? How does it work?

**Dr Ellis:** You get benefits from stopping regardless of how long you've been smoking in the past. Obviously, if you've been smoking for 50 years, you can't completely eliminate the chance of lung cancer in the future. It's going to take 10 or 20 years to get back to a normal risk level. But just in terms of lung functioning, the effect on the heart—let's face it, most of us die of heart attacks, not lung cancer. That's a tremendous impact of smoking. Those things are reversed very quickly. It's a real benefit to your heart to stop, and to your lungs.

**The Chair:** Thank you. In closing, it has been very interesting to all members of the committee that we've

had a number of presentations from the various public health units, however described, and also from your provincial association. I know I've been struck, and I believe other members have, by not only the evidence you have brought before us around smoking, but also just about the number of programs that you have developed and are putting in place in the community.

I think, if nothing else, the record of these hearings in terms of what exists in 1994 in Ontario has been extremely instructive. As the last witnesses of the day, I want to thank you for carrying on that tradition, and we really appreciate the fact that you and your colleagues around the province have come before us.

**Mr Cantin:** If you're speaking to Premier Rae, tell him to read my letter from last Friday with regard to holding tough on taxation. Just because Jean Chrétien made a major mistake doesn't mean he has to repeat it.

**The Chair:** With that, we stand adjourned.

The committee adjourned at 1552.











## STANDING COMMITTEE ON SOCIAL DEVELOPMENT

**\*Chair / Président:** Beer, Charles (York-Mackenzie L)

**\*Vice-Chair / Vice-Président:** Eddy, Ron (Brant-Haldimand L)

Carter, Jenny (Peterborough ND)

Cunningham, Dianne (London North/-Nord PC)

Hope, Randy R. (Chatham-Kent ND)

**\*Martin, Tony** (Sault Ste Marie ND)

**\*McGuinty, Dalton** (Ottawa South/-Sud L)

**\*O'Connor, Larry** (Durham-York ND)

**\*O'Neill, Yvonne** (Ottawa-Rideau L)

Owens, Stephen (Scarborough Centre ND)

**\*Rizzo, Tony** (Oakwood ND)

**\*Wilson, Jim** (Simcoe West/-Ouest PC)

*\*In attendance / présents*

### **Substitutions present / Membres remplaçants présents:**

Dadamo, George (Windsor-Sandwich ND) for Ms Carter

Haslam, Karen (Perth ND) for Mr Hope

Sterling, Norman W. (Carleton PC) for Mrs Cunningham

Wininger, David (London South/-Sud ND) for Mr Owens

### **Also taking part / Autres participants et participantes:**

O'Connor, Larry, parliamentary assistant to Minister of Health

**Clerk / Greffier:** Arnott, Doug

### **Staff / Personnel:**

Boucher, Joanne, research officer, Legislative Research Service



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## Legislative Assembly of Ontario

Third Session, 35th Parliament

## Assemblée législative de l'Ontario

Troisième session, 35<sup>e</sup> législature

# Official Report of Debates (Hansard)

Thursday 24 February 1994

Standing committee on  
social development

Tobacco Control Act, 1993

Chair: Charles Beer  
Clerk: Doug Arnott



# Journal des débats (Hansard)

Jeudi 24 février 1994

Comité permanent des  
affaires sociales

Loi de 1993 sur la réglementation  
de l'usage du tabac

Président : Charles Beer  
Greffier : Doug Arnott

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## STANDING COMMITTEE ON SOCIAL DEVELOPMENT

Thursday 24 February 1994

## COMITÉ PERMANENT DES AFFAIRES SOCIALES

Jeudi 24 février 1994

The committee met at 1006 in room 151.

TOBACCO CONTROL ACT, 1993

LOI DE 1993 SUR LA RÉGLEMENTATION  
DE L'USAGE DU TABAC

Consideration of Bill 119, An Act to prevent the Provision of Tobacco to Young Persons and to Regulate its Sale and Use by Others / Projet de loi 119, Loi visant à empêcher la fourniture de tabac aux jeunes et à en réglementer la vente et l'usage par les autres.

**The Chair (Mr Charles Beer):** Good morning, ladies and gentlemen. Before inviting our first witnesses to make their presentation, before we end this morning I'm going to ask Bob Gardner to comment on some of the material that has been distributed. But we'll wait and do that at the end of the morning.

ONTARIO PHARMACISTS' ASSOCIATION

**The Chair:** Our first witnesses are from the Ontario Pharmacists' Association. Gentlemen, welcome to the committee. Please go ahead. We have half an hour.

**Mr John Connor:** Good morning, Mr Chairman. My name is John Connor. I'm president of the Ontario Pharmacists' Association. Maybe I could ask my two colleagues to introduce themselves.

**Mr Wayne Marigold:** My name is Wayne Marigold. I'm on the executive committee of the Ontario Pharmacists' Association.

**Mr Gary Sands:** I'm Gary Sands. I'm the manager of government and public affairs for the association.

**Mr Connor:** Mr Chairman, members of the standing committee on social development, I want to thank you on behalf of the Ontario Pharmacists' Association for allowing us this opportunity to speak to you on Bill 119.

Our association represents approximately 4,500 pharmacists, including independent pharmacists, chain drug-store pharmacists, hospital and industrial pharmacists. Under current provincial legislation, we are the official negotiating body with the government on matters pertaining to the Ontario drug benefit plan and represent pharmacy in a number of areas to the government.

At the outset let me state that the OPA is in support of the objectives of the government's anti-tobacco strategy as outlined in Bill 119. We cannot, however, support paragraph 4(2)(8) of the bill that prohibits the sale of tobacco in a pharmacy.

The OPA supports the policy of voluntary cessation of the sale of tobacco products in pharmacies. This policy was supported by 62% of our members in a confidential referendum conducted by the OPA in the fall of 1992.

Our association has long been on record as supporting guidelines governing tobacco sales in pharmacies that include establishing all pharmacies as being smoke-free; prohibiting advertising, signage or any in-store displays promoting tobacco products; providing prominent display space for literature on the health hazards of tobacco use; and keeping tobacco products in a non-visible area that would require the customer to specifically request a tobacco product.

As well, in the past OPA has supported higher taxation on tobacco products, with a corresponding increase in funding for promotional and educational activities aimed at reducing tobacco use, particularly among young people, and stiffer penalties for selling to minors. But the provision of Bill 119 that would legislate the removal of tobacco, a legal product, from retail pharmacy conveys a lack of understanding about the current realities of pharmacy.

The retail, non-dispensary component of a drugstore is not only a separate and distinct entity from the dispensary but is absolutely critical to the viability of pharmacy. Neighbourhood apothecaries of the past would simply not survive, for example, in a major shopping centre in today's economy without the balance of front-store sales and the dispensary.

It is suggested that if many pharmacies do not sell tobacco yet stay in business, all pharmacies can survive without tobacco sales. This claim does not take into account various factors such as geographical location, the mix of prescription products with general merchandise in each store, hours of operation, the size of the store, the rent paid etc. This is particularly true in the context of existing government policies and initiatives taken with respect to pharmacy over the past three years.

For example, the professional fee of pharmacists paid under the ODB plan has been frozen by the government for the last three years. Last fall it was even rolled back under the provisions of Bill 48, notwithstanding the recommendations of two consecutive government-appointed mediators calling for an increase in the professional fee. The Ministry of Health has also continuously taken the position during negotiations with the OPA on the dispensing fee that it expects the retail "front shop" to subsidize the dispensary.

In the summer of 1992 the Ministry of Health delisted a number of ODB products from its formulary as eligible benefits. At the same time they implemented changes that substantially altered the level of reimbursement to pharmacists for many over-the-counter products. They did this by unilaterally deciding to stop reimbursing pharma-



cists for many OTC products on a professional fee basis which represents their professional services and expanding the list of products reimbursed on a retail markup basis. As noted in a letter on the reimbursement changes to Premier Rae in June 1992:

"As well, the ministry has advocated the removal of tobacco sales from pharmacies, arguing that the role of a pharmacist as a health professional takes precedence over their role as a retailer. We may even see legislation from the ministry in this area this fall. Now the ministry, when it suits their agenda and the product falls into the appropriate cost category, treats the pharmacist primarily as a retailer. The government can't have it both ways."

The dependence of pharmacy on the retail component has clearly been enhanced by the cumulative impact of these and other measures. This situation is becoming untenable for pharmacy and has taken a toll on the profession. The ripple effect is already being felt. Pharmacists may find it difficult to provide the appropriate level of care and counselling that we as a profession feel the public deserves.

While it is clear that the retail component of a drug-store is an integral part of the industry today, it is equally true that it is critical to its economic survival. To now propose a measure that will wipe out 10% to 15% of the revenue of the retail area will not only hurt pharmacy but will cost this province jobs, run the risk of pharmacy closings and weaken our presence in communities across Ontario as providers of an essential service and contributors to the local tax base.

The study undertaken by Coopers and Lybrand on the impact of Bill 119 on drugstores was presented to this committee earlier this month. It showed potential jobs losses in the range of 2,700 full- and part-time and a potential impact of over 100 store closings. That the government could contemplate enacting legislation that will deliberately result in job losses, particularly in a province that has been ravaged by the recession, seems incomprehensible, especially if we take into account that this pharmacy ban will not reduce tobacco consumption.

Surely at the time this legislation was reviewed by cabinet, an economic impact analysis or estimate was provided to the government. We would ask that this information be tabled with the committee.

The other reality this committee must address is that of the legal ramifications this legislation poses. To accept that the government has the legislative authority to decide what legal products can be sold or not sold by a particular retailer is setting a dangerous precedent.

The government seems convinced that by prohibiting the sale of tobacco in pharmacies, a message is being delivered to the public.

Our association has obtained a legal opinion on section 4 of the legislation, and we would submit to the committee that a strong argument can be made that section 4 of Bill 119 infringes on section 2(b) of the charter governing freedom of thought, belief, opinion and expression. As our counsel states, "Compelled expression is constitutionally offensive not because the government's message is false or because the individual disagrees with its

contents, but because it is compelled." Therefore, we urge you to give the less intrusive measures in this bill a chance to work and amend the bill accordingly by removing the section pertaining to pharmacy.

I'd like to thank you at this point, and we would be happy to entertain questions.

**Mrs Yvonne O'Neill (Ottawa-Rideau):** Thank you very much, gentlemen. I find this brief very concise and to the point and right on. I don't have any questions for you, but I do want to ask the parliamentary assistant regarding the information that you have suggested must have been provided to cabinet, to verify that, and then ask that that information be tabled with this committee.

**Mr Larry O'Connor (Durham-York):** Thank you for the question. I don't know whether there was one provided to cabinet or not. Perhaps this august body might know if there is one and might want to share that with us. They've implied that there could be one.

**Mrs O'Neill:** I doubt that they have it, Mr O'Connor. I would really like to have you ask that question of your minister. I think it would really help the deliberations of this committee if we had that information.

**Mr Gary Carr (Oakville South):** On page 5, you talk about the legal ramifications of this legislation. If this legislation goes through as is, what's your intent in terms of legal challenges? What do you plan on doing?

**Mr Connor:** I'm not sure at this time. We've formulated a defence, if you will, so I'm really not sure I'm prepared to comment any further at this point.

**Mr Carr:** On the same page, you talk about the potential job losses, about the range of about 2,700 jobs, full- and part-time, that will be lost, and 100 stores closing. If this legislation goes through, that's what you see happening, that 2,700 people will be out of a job?

**Mr Connor:** Yes. I think what we're looking at there—we make reference to a study. I think Coopers and Lybrand by most people's standards would be an acceptable standard for a survey having been conducted on this subject, and I think we would have to feel comfortable with what that survey has reflected.

**Mr Carr:** So you are comfortable with it?

**Mr Connor:** Yes.

1020

**Mr Dalton McGuinty (Ottawa South):** I want to ask you a couple of things, one relating to the legal opinion you've obtained and the other item relating to the seeming contradiction we have. As I'm sure you're very much aware, this particular provision of the bill related to the ban of tobacco products in pharmacies has been the source of great controversy. The college has asked for the ban, but your association says implicitly here that they really don't represent the majority of its members. Can you shed any further light on this? Can you tell us, for instance, that your survey is the most reliable?

**Mr Connor:** No, I don't think we could say that it's the most reliable. I think the point we want to stress in our brief, and certainly if I can re-emphasize it here, is that what we do want to communicate is the fact that we have a membership that has responded to a confidential

survey. They have requested that it be their decision as to the decision to no longer sell. On an ongoing basis, as an association, we continue in our newsletter to post names of those stores that voluntarily decide no longer to sell tobacco products.

**Mr McGuinty:** Are you aware of any other survey that has been done by anybody else, apart from one of the partisan players, the politicians or even the government in this, but among pharmacists themselves, that would contradict this 62%? Has the college done one, for instance?

**Mr Connor:** I'm not aware of one and I'm not sure we want to compete; that's not our intention here. What we did is we simply asked our membership, so that was conducted within our own association. I would have to feel comfortable that it wasn't our intention to get into a debate over figures; it was simply our association looking for direction from the membership whom we represent.

**Mr McGuinty:** You've got 4,500 pharmacists, it says. How many more are there that you don't represent?

**Mr Connor:** I think all licensed pharmacists in the province would probably total about 8,100.

**Mr McGuinty:** This legal issue, I think you've raised a good point, and it's something that I raised on second reading of the bill. I don't think you need to be a lawyer to see that there may be a problem here. I think it's one thing to say you can take a legal product and restrict its sale to a specific retailer. "We're going to sell all our beer, you've got to go to the Beer Store. If you want your liquor, you've got to go to the LCBO." But I think it's quite another thing to say, "You can purchase this product everywhere except for this store." I think there's a problem there. You've raised it here.

I think it's important for us to look ahead and to see what could possibly happen down the road in this context. I'll just ask the parliamentary assistant, did the minister obtain a legal opinion from an expert in constitutional law regarding this issue so that when this bill goes ahead we're not setting ourselves up for an exercise which will benefit some of the lawyers of this province?

**Mr O'Connor:** Thank you for that question. We do have our legal counsel here with us. I'll ask Frank Williams if he might come forward to a microphone and attempt a response to that question.

**Mr Frank Williams:** Frank Williams, legal counsel, Ministry of Health. As I mentioned earlier in the technical briefing—it seems like several months ago; it was only two or three weeks ago—at that time I expressed the view that yes, we had obtained an opinion from the constitutional law branch and we feel that there is sufficient authority to go ahead with the bill as we've drafted it.

**Mr McGuinty:** Are you aware of the nature of that opinion? Is that in writing? Can we see that?

**Mr Williams:** I'm not at liberty to go beyond saying that yes, we have an opinion and we feel we have sufficient strength to go ahead with what we want to do.

**Mr McGuinty:** You can release that surely, Mr O'Connor?

**Mr O'Connor:** I'm not sure what we have on file.

**Mr McGuinty:** I'll make that request to you. Maybe you can get back to me.

**Mr O'Connor:** I'll undertake to take a look at it.

**Mr McGuinty:** We've got an opinion here.

**Mr Williams:** I would suggest to you that it would be a confidential solicitor-client privilege. That would not be the sort of thing that would be shared normally.

**Mr McGuinty:** But who's the client?

**Mr Ron Eddy (Brant-Haldimand):** Unless the minister decides.

**The Chair:** Mr Eddy, did you wish to comment?

**Mr Eddy:** Yes, I agree with that. But on the other hand, if the minister is in control, the minister could make that decision to release it, and it would be very helpful.

**The Chair:** Okay. I think the request has been made to the parliamentary assistant, and he will respond.

**Mr O'Connor:** Of course the minister is always in control, as the member has stated.

**The Chair:** Gentlemen, we thank you very much for the written submission and for coming before the committee this morning and for answering the questions.

#### MENTAL HEALTH RIGHTS COALITION

**The Chair:** I call on the representatives from the Mental Health Rights Coalition. Welcome. Introduce yourselves for the committee, then please go ahead.

**Ms Marilyn Smith:** I'm Marilyn Smith. I'm an outreach worker for the Mental Health Rights Coalition.

**Ms Susan Roach:** Susan Roach. I'm currently chair of the board of the Mental Health Rights Coalition.

**The Chair:** Just before you start, there was some difficulty with that mike, and I just want to make sure people can hear. If I suddenly stop you, it's not for something you've said, but just so we can make sure the volume is okay.

**Ms Roach:** It will be the first time in my life I've had to have volume added.

I would just like to start by introducing what the Mental Health Rights Coalition is. We are a group of consumer-survivors, who are designated under the Ministry of Health as individuals who have had care provided of a mental health nature. Specifically, I think we're here today to speak on behalf of those consumer-survivors who still are inpatients in a provincial psychiatric hospital or who may be in the future inpatients of a provincial psychiatric hospital.

In regard to that, we're addressing two primary issues. First is subsection 4(1) in regard to the fact that a provincial psychiatric hospital may be one of those locations which will be prohibited from selling tobacco products. Currently the institution we're involved with, the Hamilton Psychiatric Hospital, is selling tobacco products both in the patient canteen and also in the gift shop or tuck shop. The second item, subsection 9(1), is in regard to the availability of designated smoking areas for inpatients of the hospital.

I'm going to assume, not in judgement of anyone, that people may not know a lot about the running of the



provincial psychiatric hospitals, at least to give you a very quick consumer perspective, which is that most of the patients at the Hamilton Psychiatric Hospital are inpatients as a result of being certified under the Mental Health Act, are being detained as not criminally responsible or are receiving forensic assessment under the Criminal Code of Canada.

In addition to that, individuals who are voluntary patients, at least initially, would be placed on what is sometimes referred to as a "locked end," which is an end that they cannot leave from the ward where they're receiving treatment, or they may be on a one-to-one with a nurse. They may be on ward privileges only, hospital or grounds privileges only.

If tobacco sales were removed from the hospital, you're looking at individuals who would not personally themselves be able to access at all tobacco for their own personal use. Compound that with the fact that a good number of patients, especially long-term patients, of which our system still has many, do not have visitors, don't have a regular support system from the community, someone who would be willing and able to provide the resource of coming in and bringing a pack of cigarettes for them.

I do not wish at any point to have this go to: "Well, should people smoke at all?" That's certainly not the argument that we're presenting, but rather the impact that these two elements of the legislation are going to have on the individuals who are currently inpatients of the hospital.

1030

**Ms Smith:** Within the walls of any institution, and specifically we're addressing the psychiatric institution, nicotine and tobacco products have had a significant value as a trading commodity. That is very much the case within the psychiatric facility. Our concerns are that if access is limited, the value of that commodity within the institution is going to be significantly raised.

I will talk a bit about the type of trading issues surrounding nicotine products at this time, with markedly better access to tobacco than there would be in the event that subsection 4(2) is a designated place for prohibition of sale.

I will refer to an article which was printed in the Hamilton Spectator, the May 5, 1992 edition, which references research done in Victoria, BC, citing that patients do offer themselves in a sexual manner for the trade of cigarettes. I might point out that it's a very limited number of cigarettes which these vulnerable people are willing to make that type of sacrifice for. That in itself, I hope, would strike any individual who had never given any thought to that matter as quite distressing and sad.

Again, given the impact of AIDS and its growing effect on our community, the issue of safe sex does fall into play. This research article indicates that the use of condoms is not frequently adhered to by patients. That's been in a circumstance where, again, there has been greater access to tobacco products. If it's going to be limited, patients may be engaging in that type of activity

more frequently, thus raising significantly the chance of that health issue coming into greater play within the psychiatric facility.

Other issues of trade involve patients being manipulated into trading personal care items that they may have: clothing, radios, the like, things which they consider great luxuries. Many patients are living on a comfort allowance of \$112 a month. Their access to luxury items, let alone cigarettes, is quite limited, and the prohibition of sales and the effects which I've briefly voiced are going to adversely affect them in the material sense.

**Ms Roach:** One of the other real, primary issues that we see potentially arising, in particular out of subsection 9(1) where we're talking about the limitation of designated smoking areas, is that currently at the hospital each ward has its own designated smoking area where patients, regardless of their privileges, basically from the time they wake up till the time they go to sleep, are able to access somewhere that they can smoke safely.

Maybe the other important part of this is that it's done safely for the benefit of others as well. If we talk about reducing the number of designated smoking areas, quite possibly to the extent that there's one area kind of serving the hospital as a whole, you're looking at a number of ramifications.

You're looking at people who can't get there because their privileges restrict them to a ward. You're talking about all patients, who, after the hospital shuts down at 9 pm, will suddenly not be able to access a smoking area. You're talking about increased stress on staff who try to police a situation around where smoking takes place.

You have an increased problem with the potential for fire because people who are undergoing a lot of stress are going to have a cigarette anyhow, even if they can't get to the safe area, maybe smoking inappropriately, say, in a bedroom. The risk of fire increases, which jeopardizes patients who are smokers, but it also jeopardizes non-smoking patients, staff and visitors at the hospital.

One seemingly small piece of legislation is going to have a large impact on a significant number of people and on a number of people who are already vulnerable and are going to be placed at greater risk.

**Ms Smith:** There has been clinical research done on the interrelationship between smoking and schizophrenia. I'm citing a study done by James Lohr and Kirsten Flynn which found that there is an indirect evidence that nicotine is important in maintaining the smoking behaviours of schizophrenics. That is so because of the effect of nicotine on dopamine, a brain chemical. They indicate that it is possible that nicotine may cause a decrease in negative schizophrenic symptoms.

We're not talking about the issues of dependency that a member of society not afflicted with a form of mental illness may face in relation to a nicotine addiction; we're talking about a condition quite aside from that which is impacted by nicotine. It is the belief of our organization that if you curtail access to the product itself or an area where people may legally consume that product, they're going to adversely suffer the effects of the illness for which they are in the facility to gain treatment for the

purpose of exiting the facility, and that would be much to their detriment.

**Ms Roach:** We're kind of moving around here, but one of the other interesting things—I don't know who follows the Hamilton media; I don't recognize anyone here from Hamilton—is that Hamilton has had this real issue lately about elopements from our provincial psychiatric hospital. It's an issue that generated considerable community response, not too much of which was of a positive nature. The reason I'm pointing that out is that we had four individuals leave, the press picked it up, it was a major issue.

If we don't have cigarettes available at the hospital for purchase by patients who cannot leave the hospital, who do not have visitors who will bring them cigarettes, they are going to have one option. That one option is going to be to leave the hospital to purchase the cigarettes or potentially rely on a black market trade from someone who will bring them in, but they're going to pay an escalated price.

We're putting ourselves back into the corner of elopements, which is already problematic in our community. For a government which is concerned about black market trade, basically you're generating one at our hospital because people are going to have to rely on some other means to bring these cigarettes into them, and it's not going to be a fair exchange value that's going to result in that process.

1040

**Ms Smith:** On the issue of elopements, there are two matters. One is the effect that publication of the event would have had on the individuals who had taken leave of the hospital and the detailed information made public, and its impact, which would be adverse to that individual. One may question the issues of salience of printed information.

A secondary concern, and from the point of the provision of care a very fundamental concern, is that as individuals may be stepping outside the boundaries which have been afforded to them physically, be it leaving the grounds when they have grounds privileges, be it leaving the grounds when legally they are required to be there, nursing staff care providers are going to have to direct a great deal of their attention towards policing functions to monitor the presence of their patients.

That is going to detract from the time and attention they can devote towards their patients for the purposes of care. I would think that, in the long run, that's going to draw out hospital stays, negatively impact on that, and represent itself not as either a very therapeutic environment or a cost-effective one.

**The Chair:** I just want to be clear. I'm going to show my age again, as I have done through these hearings, but when you speak about elopement, you do not mean going off to get married but simply leaving the hospital grounds?

**Ms Roach:** Leaving against whatever privilege base they have, yes.

**The Chair:** Right. Mr Sterling and I need to be sure that we're clear on that. Thank you.

**Mrs Karen Haslam (Perth):** Are you passing around your wallet again, Mr Beer?

**Ms Roach:** Just to conclude, I would like to point out that I at least, speaking for myself, have been a patient of a provincial psychiatric hospital and have been in the position of always being fortunate enough of having family and friends visit, of always having some base of income and being able to afford to purchase cigarettes, but have always been very well visited by everyone else in the hospital because they don't have that same opportunity necessarily.

You watch within your own unit the level of anxiety increase, you watch the level of frustration increase, sometimes to a point where the person is then placed in a base of being in seclusion or needing additional medication in order to deal with everything that's going on at that particular moment. I'm not going to say that cigarettes alone are the cause. I think, in part, though it's the interplay of the two of them together, that when your coping skills are already minimized when you're ill, to cope with not having cigarettes available or be able to purchase them creates a very difficult situation for people.

We really struggled in our conclusion in terms of using the word "discriminate." In fact both Marilyn and I had an ongoing debate about this particular issue. I think we would like to believe, and I think we do believe, that it's not a malicious, "Well, we're kind of out to get the psychiatric population and this is one way of making their life miserable." I don't believe that's the issue.

I do believe, however, that the legislation has the result of being somewhat discriminatory in that a large number of people who will not access the product will not have a place to smoke, keeping in mind that a lot of psychiatric patients are in hospital for six, seven, eight months at stretch, that those occur repeatedly throughout their lives and that this is the one thing, albeit maybe not particularly healthy, that has always given them some satisfaction.

**Mrs Haslam:** On page 3 you talk about designated smoking areas. As a point of clarification, do you also have other common areas for people who choose not to smoke?

**Ms Roach:** Yes. Each ward actually has four areas, two smoking, two non-smoking.

**Mrs Haslam:** When you talk about exploitation of patients trading radios, clothing and food, I just wonder where the staff figure in on this, if they see it happening. What do the staff do in these instances when it seems to be detrimental to the mental health of the person, when it's not exactly what you'd like to see going on in a health facility? If it's that bad, how is it being countermanded presently and is there some way that staff can work on these issues? I don't see it as being just a tobacco issue is what I'm saying.

**Ms Smith:** No, it's not just a tobacco issue, but when an individual seeks treatment or is placed in a facility for treatment, that doesn't necessarily mean, in the common law, that they can't engage in acts of bartering, and it's not necessarily the role of a care giver to intervene in that type of a trade if there's a system that has been set up so



that an unfair situation occurs for an individual.

**Ms Roach:** I think generally the hospital staff attempt to intervene. However, it depends on whether the person complains about it, and that's I think really where the crux of the argument is. We know, as other patients, other consumers, that it's happening. We know that it's like a radio for three cigarettes, because the person really wants cigarettes. Because the person got their cigarettes, they're generally not complaining about it, but you would have to question whether in all cases they really understood the impact of the decision they made.

**Mrs Haslam:** We're talking about one item in a system that is already operating and that's why I'm asking you. If it's going to go on, it is going to go on and the staff know it's going on, the presence or elimination of tobacco in that system is not something that you can control no matter what the legislation says because you will still continue to see these kinds of activities go on. That's my point.

**Ms Smith:** Our concern is, though, that it will elevate.

**Mrs Haslam:** Yes, I understand that, but it could be chocolate Milk Duds too.

**Ms Roach:** They don't have the same trading or commodity value.

**Mrs Haslam:** But they could have, if they were a similar product that everybody wanted. That's all I'm saying, that you're talking about a product, but that's neither here nor there for the system being in place continuing to be in place. I understand your concern about it, looking at the parameters of that system, but I fail to see the link with the—

**Ms Smith:** On the issue, I too have been an inpatient of a psychiatric facility and have been fortunate enough never to have found myself in a situation where I would be willing to engage in that type of activity. But when I became aware—and it is women; I've not heard tell of a male engaging in sexual activity for the trade of a cigarette. That saddens me. I have not heard of anyone willing to sleep with someone for Milk Duds.

**Mrs Haslam:** It's not Milk Duds; it's just a product. That's it.

**Ms Smith:** I'm not meaning this to you lightly. Really, it saddens me, and that will happen for tobacco.

**Mrs Haslam:** Can I ask a quick question?

**The Chair:** Sorry, just about everybody wants a question here. I think we've only had one or two presentations around this specific issue and I just want to try to allow everyone to get in.

**Mrs O'Neill:** Thank you for a very powerful presentation. I think this is the second time this issue has been brought to the committee, but you are speaking at first hand, and I think that makes it very different. I'd like you to say a little bit more to us about the designated places and then I want to ask a question of the parliamentary assistant regarding this. You say that hospital shuts down at 9 pm. Does the designated smoking place, however, remain open? Would people still have access to that?

**Ms Smith:** As things are, and it's my understanding of the proposed legislation, subsection 18(1) confers upon

the Lieutenant Governor the privilege to allow it to remain so. Patients have access to on-ward smoking areas after 9 o'clock.

**Ms Roach:** There essentially is one common area in the entire hospital that's kind of linked with the patient canteen and then there are the smoking areas on the individual patient wards, of which this hospital has eight.

As it stands now, yes, right until somebody goes to bed they can basically access the smoking area. The concern then is that if we're making some changes and some alterations in the accessibility to the wards, the worst-case scenario would be that it would be the one common area for the hospital and that people would need to go there. If you did that, the impact would be after 9 o'clock, when the ward shuts down.

I'm using probably the wrong term. It's not open to visitors. The door's locked; it's not the outgoing, ingoing flow. We're looking at the worst-case scenario which we wouldn't want to see happen. We tried to identify what some of the consequences of that would be and that the need really is to have some ongoing ward availability for people without privileges to leave the ward, that type of thing.

1050

**Mrs O'Neill:** Would your coalition be asking to have these areas ventilated to the outside?

**Ms Roach:** Certainly.

**Mrs O'Neill:** You haven't done that yet.

**Ms Roach:** I don't think there's anything beyond the availability, which is our concern right now. We think other things in regard to ventilated and properly set up should all still apply.

**Mrs O'Neill:** If I may ask the parliamentary assistant, is this a consideration regarding regulations, the exemption that's possible in this case?

**Mr O'Connor:** One of the purposes of going through a public hearing process for the presenters here is that in regard to the legislation as it's drafted and presented in the House, the members themselves in the Legislature of course may have some concerns, but they don't have the depth of knowledge that is out there in the community.

Part of the purpose—I'm saying this for presenters as well—is that you go out to the public and you draw on that expertise and hear what people have to say in their comments on the bill and then take a look at it. So the information that you have provided will give us some insight that we didn't have before.

It's my understanding that as the government went through this process a year ago within the ministry, we went through a public process before with the draft legislation. We heard from 240 different people in written submissions and 34 oral presentations. This does offer something that's a little bit different than what we've heard so far as well as what we've heard now. So to answer your question, this is important input as well and we'll consider it.

**Mrs O'Neill:** We consider it very important input.

**Mr Norman W. Sterling (Carleton):** Can I just ask you, where presently in psychiatric institutions are

cigarettes normally sold to inpatients?

**Ms Smith:** In the case of the Hamilton Psychiatric Hospital, there is a coffee shop which is directly facing the front entrance to the hospital and there's a patient canteen located in a basement area. Something alongside of that, profits generated from sales made in both of those venues are redirected back towards patient activities and very often the moneys are utilized to provide outings, some types of pleasantries for the patients that are not otherwise afforded to them within the mandated budget of the facility.

**Mr Sterling:** I'm inclined to support your position and would be quite willing to amend or vote against this particular section of the bill which would exclude psychiatric institutions. What is the argument on the other side that might be presumed? I know that's not what you're here for, but is there another side to this or is it just a matter of lack of consultation?

**Ms Roach:** I think one of the contributing things, and it may fit what Ms Haslam was saying as well, is that one of the things that's always been dramatically overlooked with the psychiatric population is that yes, they do have a high level of smoking, so it does drive this kind of need and want. But I have never in all my years, which is 22 years in the psychiatric system, seen anyone attempt to provide a smoking cessation program for consumers taking into account their specific needs, driven by their own symptomology, the fact that when you only have \$112 a month as a comfort allowance you don't have \$70 to go out and join the Lung Association's quit-smoking program.

Part of this is, as much as anything else, I'm a smoker and I would love to see us working also towards helping people quit smoking. That's not something that's been looked at to date and it's not something that either the hospital or any outpatient psychiatric program has attempted to do.

**Mr Sterling:** All I can say is unless I hear something in between now and next Tuesday or Monday, in two weeks I'll be supporting your position and putting forward either an amendment or voting against this particular section on your behalf.

**Ms Roach:** Thank you, sir.

**The Chair:** Mr Owens and Mr McGuinty, and that will conclude the questions.

**Mr Stephen Owens (Scarborough Centre):** Thank you for your presentation. I was quite interested in the reference in the literature with respect to nicotine and its effect on dopamine levels in schizophrenics. Has this result been replicated in other studies?

**Ms Smith:** With the research briefs that I have been provided, no. I received a fairly limited bibliography of research devoted to that area, so that is the only study with that supportive conclusion that I have to access.

**Mr Owens:** I appreciate your comments with respect to smoking cessation programs. I don't think anybody on this committee or perhaps in the province can stand and say, "Smoking is the greatest thing since sliced bread and we should all do it," and of course as a government we're in a bit of a bizarre position with respect to known health

effects versus revenue generation.

I think that in terms of the kinds of programming that you would see as being facility-appropriate, do you have any suggestions on the kinds of things that perhaps the Ministry of Health could be looking at with respect to cessation programs that could be designed around the kinds of needs that folks in your facility would have?

**Ms Smith:** Susan did make reference to things such as the availability of the patch. If I may refer to my own situation, I am quite aware of the negative physical ramifications that can arise from smoking. It does serve to calm and appease me during tense times and I don't know that there is anything that can be afforded to patients, with the exception possibly of upping people's sedative prescriptions and so forth, which might provide them with the same type of calming effect that nicotine does.

**Mr Owens:** In terms of sales to the public versus your residents, and again I don't think it's anyone's view on this committee that we want to add to problems already being experienced by inpatients, then in terms of the retail area, perhaps the front of the facility or the more public area, can you tell me what controls are currently there to prevent, say, the sale of smoking to minors, and what would you propose as a recommendation that sale for the purpose of public consumption be eliminated but then in terms of your residents that cigarettes be made available in some way through a retail service?

**Ms Smith:** Minor access to the facilities is quite limited. From time to time, adolescents may be admitted to the facility.

**Mr Owens:** But in terms of visitors—

**Ms Roach:** The hospital only admits people 18-plus; we don't admit under that. But I think in recognition of what you're saying, certainly staff are a relatively primary purchaser of the cigarettes at the hospital as well. I'm sure that something could be put into place that would say, "No, these are now for sale only in the patient canteen, and even if staff go in there, they're not negotiated for sale with staff." We may have a few annoyed staff for a while but I think that's easily implemented. There was another part of your question which I've—

**Mr Owens:** The access to the product.

**Ms Smith:** In all honesty, there are not a great many minors who frequent the facility to visit. Occasionally you see families coming with very young children. That's quite atypical.

**Mr Owens:** Presumably, they're not—

**Ms Roach:** We're still a somewhat stereotypical institution that doesn't draw a high visitor base.

But if I can just very quickly jump back to the part of the question about smoking cessation programs, do not attempt to implement them while the patient's in the hospital—the stress is too high—but try to implement them for almost immediately after their discharge so that they're being discharged and it's part and parcel of that follow-up, and a big part of that programming would have to address stress management even over and above any traditional quit-smoking program.



1100

**Mr McGuinty:** Thank you both very much for what I feel is a very important presentation. I don't think there's any doubt whatsoever that this particular provision we're talking about here is clearly discriminatory against psychiatric patients who are confined to hospital.

When I look at this act, it doesn't say anywhere here that its intention is to prohibit anybody from smoking. It doesn't even prohibit kids from smoking; it just says you can't sell to them. Effectively, if you read between the lines, what we're saying is, "Listen, if you're a psychiatric patient, if you're confined to grounds or to a ward or to the hospital itself, you can't leave the grounds, first of all, and second, nobody can come on the grounds to sell cigarettes to you." If that's not discrimination, I don't know what the heck is.

It's rather perverse when you compare it to our jail system. If I have committed an assault and severely beaten somebody deliberately and I'm confined to jail, I can buy my cigarettes there, but if I'm subject to an illness, something that's beyond my control, and I'm confined to an institution, I can't get cigarettes.

Let's not lose perspective about this stuff. We are talking about psychiatric illnesses. In the grand scheme of things, cigarette smoking pales in comparison to the complexity of a psychiatric illness, so let's not get carried away with the stuff. I hope to God the government is going to correct this so that psychiatric patients can buy cigarettes on the grounds and avoid all the problems inherent in not doing so.

**The Chair:** While we've gone somewhat over time, as was noted earlier, we have not had many discussions on this particular point and I think it was very helpful for the committee. Thank you both again for coming.

**Ms Roach:** We thank the committee for your time.

**Ms Smith:** Yes. Thank you for your time. We have a list of signatures from members in Cambridge in support.

**The Chair:** That's fine. If you'd give it to the clerk he'll be able to make copies for each of us.

LISA PRINN

ROBERT CASTLE

**Ms Lisa Prinn:** My name is Lisa Prinn. I'm from Sheridan College in Oakville.

**Mr Robert Castle:** My name is Rob Castle. I'm the general manager of the student centre at York University and the communications director of the Association of Managers in Canadian Campus, College and University Student Centres.

**Ms Prinn:** We have come to speak to you on behalf of the colleges and universities of Ontario, which represent nearly half a million students. First, we'd like to commend your efforts on Bill 119 so far, though we are here to ask that some modifications be considered concerning section 9, paragraph 2, which is under the title "Controls Relating to Smoking Tobacco."

Our concern is based on the fact that the bill presently states that there will be no smoking areas designated anywhere on post-secondary campuses. We wish it to be reworded to state that only the actual municipal buildings

be affected. This would leave our student centres and surrounding land the freedom to designate smoking sections.

Student centres are built, owned and maintained by incorporated bodies through the use of student fees. As it is wholly the students' moneys concerned and they have requested representation of their views, a questionnaire was implemented and tabulated at Sheridan College, Oakville campus. The questionnaire was completed within a two-day period by 544 students at different venues throughout the institution.

The results indicated that 98.4% of Sheridan students are against Bill 119 as it presently stands, with the inclusion of their student centre and surrounding areas. Out of the 140 non-smokers who responded, 114 were in favour of keeping some sort of smoking area available to smokers, namely, the student centre.

Presently these facilities act as an outlet for student activities and licensed social events. Smoking and non-smoking students alike are concerned that support of these events will be drastically reduced as business is taken to off-campus establishments.

In compliance with the municipality's regulations and administrative bylaws, student centres are highly regulated for the safety of their students. If smoking areas cease to exist, students will likely proceed to off-campus establishments that do not offer as controlled an environment.

Post-secondary students have stated agreement with the intent of the bill's provision of tobacco to young persons. They understand the statistics concerning tobacco addiction in youth at a secondary school level. However, since the average age of post-secondary students is between 24 and 26 years old, the possibility of this bill preventing or reducing students' smoking addictions is unlikely.

The financial feasibility of maintaining this bill must also be considered. The amount of money required to enforce non-smoking on campus could become phenomenal, considering many post-secondary institutions are situated on large, diverse campuses consisting of many acres of land. Individuals who continue to smoke indoors will resort to doing so in washrooms and locked offices or classrooms to avoid being caught. This in turn infringes upon non-smokers' rights.

I would like to stress again that student centres are maintained and subsidized by revenues generated from their licensed events. The financial responsibilities related to the operation of students centres will be greatly affected by Bill 119, leading these establishments into financial difficulty, possibly bankruptcy.

Leaving you with this thought, I trust that your decision to redefine section 9, paragraph 2 which states, "a school, post-secondary educational institution or private vocational school" will be changed to accommodate the above-stated needs. One possible solution may be to exempt "post-secondary institution" from paragraph 2 and create a separate subsection.

I would like to thank you on behalf of the post-secondary students. If you look at the next page of this report, I have the results of the questionnaire that we did on

campus. They're also right here if any of you would be interested in reading through them.

**Mr Castle:** I'd like to start off by thanking Ms Prinn for inviting me to share her limited time here before the committee this morning. I appear before the committee on behalf of the York University Student Centre and other student centres across the province regarding concerns over section 9, paragraph 2 of Bill 119.

Though we are generally supportive of the overall intent of the legislation, limiting use of tobacco by minors and limiting the sale of tobacco, the provisions of paragraph 2 would prove onerous to our operations and would not be in the interests of campus life. As you are aware, paragraph 2 would ban smoking at post-secondary institutions. As I understand it, officials of both the Ministry of Health and members of this committee have confirmed that this would mean a total ban on university and college properties.

Universities and colleges are very different creatures from public and vocational schools. There are many factors which speak to the need to deal with post-secondary educational institutions separately under the legislation. Most campuses are self-contained towns or cities within their respective municipalities. We generally have our own distinct cultures and rules which govern our unique communities. As well, university and college students are adults in the majority. Indeed, the average age of an undergraduate student at York University is 27.

York University has a campus population of 54,000 students, staff and faculty. If you will, we are a city with the population of Barrie, spread over 650 acres. As well, over 4,400 people make York their home in the campus residences. To service this community, there are over 30 on-campus restaurants and pubs. You can imagine that enforcement on a territory of the size and varied nature of York will be next to impossible. This holds true on campuses across the province.

The operations I represent, both at York and throughout Ontario, contain a large portion of the restaurant and bar services located on campuses. At the York student centre, we have a full-service restaurant and nightclub licensed for 700 as well as a food court with seven nationally branded commercial outlets with a capacity of close to 600.

Neither of these operations would be able to compete with off-campus locations that would not be subject to similar restrictions. If we were subject to stricter rules than our competitors, we would not, and forgive the cliché, be playing on a level playing field. There would be no equity.

The city of North York has recently implemented one of the toughest smoking bylaws in the region which, I believe, could stand as a model for municipalities in Ontario. We believe that respecting the North York bylaw respects the interests of all parties by striking a strict, but reasonable, balance between the smoking minority and the non-smoking majority.

The major difference, it seems, between the North York approach and the proposed legislation is that under the North York model similar businesses are treated

similarly within the context of the wider community. We are simply requesting this regime of similar treatment continue to exist for on-campus business operators.

It is important for the committee to recognize that student centres are not funded from the public purse. Unlike academic facilities on campuses, our centres are generally funded through direct levies paid by students on top of their academic fees.

As an example, the York University Student Centre was built at a cost of \$24 million, \$21 million of which is paid directly by students. The CAW student centre at the University of Windsor was built at a cost of \$10 million, \$6 million of which is paid directly by students and the remainder by private donations.

These centres receive operating subsidies neither from university or college administrations nor from the province. We are freestanding operations which are supported by student fees and our business revenues.

#### 1110

Excess revenues from the student centre operations are used directly to support activities for students. Though not identical at all campuses, these activities include support for multicultural groups, sexual harassment and abuse counselling, literacy programs, and other community services.

We attempt to provide our students with a healthy, positive environment where they can relax and enjoy themselves without having to leave campus. Adherence to paragraph 2 would in time reduce our client base significantly and would no doubt force the closure of many of these on-campus operations.

A major component of student life would be threatened by such a prohibition. If we drive students to off-campus operators, then the work we have done at universities and colleges across the province to encourage the development of responsible lifestyles may have been in vain.

The committee should also be aware of the impact paragraph 2 would have on our residence communities. Our campuses are home to thousands of students. Those who smoke within the confines of their own home might now be subject to fines.

Colleges and universities have tended to be at the forefront of the campaign to restrict smoking areas. Most campuses over the last five years have addressed the issue of smoking areas through representative committees. The resultant policies have often been more strict than the bylaws of local municipalities. We are now seeking a balance.

On behalf of student centres across the province, I am requesting an exemption from paragraph 2 for commercial food operators and licensed facilities on college and university campuses. These areas would continue to be governed by local bylaws.

Specifically, we would recommend that the term "post-secondary institution" be deleted from paragraph 2 and that a separate subsection in section 9 be added to read:

"No person shall smoke tobacco or hold lighted tobacco in any of the following places:

"A post-secondary educational institution, except an



area within the institution which is exempted by municipal bylaw."

This amendment, based on similar language of the existing section 9, paragraph 1, would allow restaurant and licensed areas as well as residences to be governed by local regulation.

In closing, I would ask that members of the committee recognize the diversity of university and college campuses and further recognize the need for these communities to be dealt with separately under the legislation.

**Mr Carr:** Thank you both for your presentation. I was interested in knowing what percentage of the student population would be affected by this, and maybe you could talk about York and then Sheridan. I'm from Oakville, so I'm close by. What percentage, do you know, would it be at your institutions?

**Mr Castle:** That actually smoked?

**Mr Carr:** Yes.

**Mr Castle:** Very difficult to say. To my knowledge, there hasn't been a comprehensive survey that would be able to give us that sort of information.

**Mr Carr:** No ballpark figures?

**Mr Castle:** I would think that it would come close to mirroring the general population, so probably 30% to 40% of students would smoke and 60% to 70% would not. Quite naturally, in terms of the operations that we represent, as I mentioned, we represent bar operations and so forth on campus. A number of our patrons, probably a higher portion of our patrons, smoke than don't.

**Mr Carr:** I take it you don't have any numbers for Sheridan as well.

**Ms Prinn:** No, not really. We already got 10% of the students filling out these questionnaires and basically 90% of those wouldn't smoke. I'd probably say it's about 30% to 40% of the total population also.

**Mr Carr:** What do you see happening if this goes through and doesn't change? I like some of the ideas you put forward and appreciate the fact that you put it into amendment-type form. If this goes through as it is, what do you see happening when it's passed? What are the students talking about doing?

**Mr Castle:** I think there are a couple of issues; first, the issue of enforcement, and I recognize that under the legislation the owners and operators of these facilities are not required to enforce but merely to place signage. At our communities we tend to find that if signs go up and they're not enforced we get complaints, so we do have to address the issue of enforcement.

The university is spread over 650 acres. We have woods, we have marshes, we have creeks, we have trails. The idea of enforcing an outright ban is an impossibility. The resources of the university's security force—we will have four to six officers on duty to patrol a small city, so their ability to enforce is very limited.

We will see a direct impact on those areas that we manage. The student centre, because of its business operations, will see a net loss of student customers to off-campus locations.

**Mr Carr:** What you seem to be saying is it's not

going to work anyway. Even if the legislation comes through, it's not going to stop the smoking in your institution.

**Mr Castle:** I don't believe it's possible through this legislation to successfully have an outright ban on university and college campuses.

**Mr Carr:** Thank you. Good luck to both of you.

**Mr Tony Martin (Sault Ste Marie):** I'd have to say to Lisa that it was great for me personally to have had the opportunity to speak to your group when your provincial organization met in Sault Ste Marie a few weeks ago so that you might bring very forcefully to me your concerns around this.

As a matter of fact, it was interesting that of all the issues we discussed that day—tuition fees, ancillary fees and all of that—this is the one that, if you'll excuse the pun, created the most heat. We went on for a good 45 minutes, I'd say, on this. I certainly heard a lot and learned a lot in that and in fact brought back some of your concerns to the ministry. I think there is some consideration being given at the moment to how we might respond to some of your concerns.

Certainly the environment within colleges and universities has changed drastically over the last 10 to 15 years. I know when I was in university, the sum total of my smoking career was about two weeks when I thought that cigarette smoking would relieve my anxiety in a particular three-hour class where, after I had an hour, I was climbing the walls and I needed something and I saw people smoking all over the place and they seemed to be enjoying themselves. I thought I'd try that too, but I almost fell out of my chair and that was the end of that. In fact I even brought a pipe in.

This was back in the early 1970s. Pipe smoking, cigarette smoking was the norm at that time in classes. I know today that's an out for sure. I know the institutions that you represent have gone a long way to in fact put smoking areas in place that have the best possible ventilation systems and all of that.

I know the arguments that you made about the fact that the population in universities and colleges now is no longer the late teens and early 20s; it's the lifelong learning pieces kicking in and you have an awful pile of adults now attending university and college. This piece of legislation is particularly directed at kids and children. It leaves an area of grey that I think allows us to begin to maybe look at how we might be more accommodating.

The question I have for you is, at this point in time, what's the process in colleges and universities to determine what areas will be smoke-free and what areas won't?

**Mr Castle:** I think it varies from campus to campus. York some years ago, because we tend to find ourselves often at the forefront of the forefront on some issues, struck a campus-wide representative committee which was made up of faculty, staff and students. I think usually the process of most campuses is a consultative one, to work with interested parties, stakeholders, if you will, to determine how best to allocate areas within the facility where you can have smoking areas.

Under the current North York bylaw, which has sort of caught up to the York position and actually gone beyond where we were, academic buildings are now de facto smoke-free because, under the North York bylaw, you have to have separately enclosed and ventilated public spaces if you want them to be smoking areas.

The university is not in a financial position to take a student lounge, enclose it and spend the money to put in the ventilation systems, so by enforcing the North York bylaw, the only smoking areas now tend to be within the commercial areas. The limit of the areas within those commercial facilities is very strict, to a maximum of 40%.

**Ms Prinn:** This is true also in most colleges in Ontario right now just due to bylaws and the actual school administration. We don't sell tobacco on campus and we have to designate our own student centres as the only smoking areas. A lot of faculty members go outside to have a cigarette also. Classrooms and hallways—there are no lounges within the municipal building itself.

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**Mr Martin:** Given that this time of life, college and university, for a lot of students still, the student particularly going from high school to university, is often a time of great anxiety and energy, I know of parents who have come to me and said they really liked this piece of legislation because where they tried at home to set a standard and an environment within which smoking was not acceptable, their student, their young man or woman, has gone off to university or college and come back a smoker.

Do you understand, though, given the particular circumstance that you present today, the underlying principle and attempt of this legislation, which is to cut back on smoking? Do you understand the damage that it causes to people and the great cost?

**Ms Prinn:** To that, if these younger people are feeling that pressure, they won't start smoking because there is an area on campus to smoke. They'll be smoking at parties or after school or hanging out with their new friends. If you look at the areas designated right now to smokers, it's very minimal. Our student centre only holds about 300 during the day, 300 people who can fit in there and smoke. If you look at the school's population and the amount of smokers, that's hardly anything and it's off to the side.

**Mr Martin:** What about those who go there who don't want to be exposed to the environmental smoke?

**Mr McGuinty:** Thank you for your presentation. I think again it highlights a shortcoming in the bill. On the face of it, the bill says that no person shall smoke in a post-secondary educational institution. I think it's logical to infer from that that means everywhere. Out on the sidewalk but on campus grounds you can't smoke, again keeping in mind that the intent of the bill is to make it harder for kids to start in the first place and also to some extent to control non-smokers inhaling secondhand smoke, to limit that problem. Would your proposed amendment here allow smoking in bars on the university?

**Mr Castle:** It would allow smoking within a desig-

nated area. Using again the North York model, they differentiate between enclosed public spaces and a restaurant facility. Within a restaurant facility you can have a maximum of 40% as a smoking area. The smoking area has to be contiguous seating area and you cannot require a non-smoker to walk through a smoking area in order to access a non-smoking space. So yes, there would be smoking allowed, but within a balance.

**Mr McGuinty:** Right. Lisa, you would be in agreement with this amendment for purposes of colleges?

**Ms Prinn:** Yes, I definitely would. I just believe there should be some area that the students could go to.

**Mr McGuinty:** I think you've raised some good points about the difficulties associated with enforcing university students, but compelling them not to smoke is I think getting into absurdities here.

Something I think you've got to recognize is that, as we've heard time and time again from expert presenters, tobacco is a highly addictive product, comparable with the addictive qualities of cocaine and heroin. You're not going to make people stop just because they happen to be going to university or college, and I think it's important to be realistic about that problem and to address it.

In fairness to the parliamentary assistant, I think he's indicated a couple of times now that it's not the intention to have this apply to residences on campus, which makes eminent good sense. We'll see if we can tighten up the rest, or loosen it up.

**Mr O'Connor:** Just to clarify some of the intention, the intention is that when young people, young adults, go on to post-secondary education, they have the right to that education in a smoke-free environment. You've clearly pointed out that having it defined the way it is raises your concerns that it goes beyond the parts of the campus that are designated for educational purposes.

I thank you for making that presentation to us. I'm sure you understand where we're coming from with this designation because it's all part of a comprehensive strategy. I appreciate your coming and sharing your view.

**The Chair:** Thank you both for coming before the committee this morning, for your presentation and for your recommendations.

METROPOLITAN TORONTO HOMES FOR THE AGED  
ONTARIO ASSOCIATION OF RESIDENTS' COUNCILS

**Ms Mary Ellen Glover:** I'm Mary Ellen Glover. I'm the executive director of the Ontario Association of Residents' Councils. Mr Carrick not only is president of the Fudger House residents' council, but he's one of our vice-presidents. He asked me to come along with him today just to add a few comments.

**The Chair:** You're both very much welcome, and please go ahead with your presentation.

**Mr John Carrick:** Thank you, Mr Chair. I also wish to make you aware that I'm a member of the Metro homes for the aged division, and I'm speaking on their behalf as well. I have their full support in my submission for your consideration.

In the past year all the homes for the aged have been dictated by the Minister of Health as to the smoking



facilities in each of the homes. These have involved quite extensive renovations in all of the homes, to wit, having a designating smoking area. The homes have already achieved this goal in their renovations and they now have designated smoking areas within each area of each building.

As a matter of interest, these renovations at Fudger House alone, which is one of 28 homes for the aged in the city, amounted to over \$60,000. This seems to be adequate for the residents to be able to follow their, should we say, unsatisfactory habits in so far as smoking within the buildings is concerned. I for one must admit that of my 75 years, I have smoked for 55 of those years, and I have no intention of stopping or changing at this point. That's just a side issue.

But one of our major concerns is that Fudger House is at the corner of Sherbourne and Wellesley in the downtown area. We have over 250 residents within our own home and, needless to say, they all are in excess of 65 years of age. Many of them are not as mobile as you and I, and in the matter of being able to obtain tobacco products, cigarettes, pipe tobacco or whatever, it places them in jeopardy in so far as they have to cross one of the major thoroughfares within the downtown area. Needless to say, it's extremely hazardous.

We have operated a gift shop where cigarettes and tobacco are available within the building. If this were to cease, we would be subjected to black marketeers coming into the building, and not only from the outside. Even our own residents would be given to the temptation to deal in the black market of providing cigarettes to those who cannot get out.

I feel this is a major hazard to the health and safety of the residents confined to the building itself. If I might go further, in my own case I think that if I were to quit smoking after 50 years, the frustrations and the anxieties and the stress in that would not be very conducive to a happy atmosphere within my own frame of mind. So much for that, the black market.

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Now, I do stress that the location of our home is such that we would certainly appreciate being able to provide this service: in the interests of safety and health to sell tobacco products to our own residents. True, we have volunteers coming in, but I would like to make the point that they not be included in the obtaining of cigarettes, nor should any visitors bring cigarettes into the home. We administer who should have and should not have access to these bad habits, and that's rigidly enforced within the home.

Before I turn the microphone over to my cohort, I would say that we have been in close association for a number of years, and she represents the homes for the aged all throughout the province. I would like to introduce my cohort to you, Mr Chairman: Mary Ellen Glover.

**Ms Glover:** Thank you, Mr Carrick. I won't keep you long, ladies and gentlemen. I just have a few comments to add to what Mr Carrick has said.

It is a great concern of our association that you intend

to limit the sale of tobacco products in long-term care facilities, because we believe that, by doing this, you're contravening residents' rights. You have to keep in mind that the people who live in long-term facilities, as Mr Carrick pointed out, are generally very elderly and frail, and in a lot of instances they have few small pleasures left to them. Smoking is one of them.

Now, this generation doesn't consider smoking to be a pleasure, but people who are 80 and 85 do consider it to be a pleasure. They grew up in an era where it was not considered to be the health hazard or almost the crime that it is considered to be now. You also have to consider that most of these people are not concerned tremendously with shortening their lives, because they've all lived a good deal longer than we have.

One of the things you should take into account also is that, right across the province, most long-term care facilities have very effective smoking policies in place. They have designated smoking areas, and these smoking policies have generally been worked out in cooperation with the residents and the administration of the home. In all instances that I've encountered, even non-smoking residents feel that residents have the right to smoke.

I can tell you a couple of stories about the home that I have my office in, because they don't sell cigarette products in that home any more in the tuck shop. It's kind of sad, because every day I encounter a lady in the lobby who is bumming cigarettes because she has nowhere to get them. She has nobody to bring them in to her. She has no family. I guess she doesn't have very many friends. So that's how she spends her day: She goes around asking people if they would have a smoke.

I can add to what Mr Carrick said about banning the sale resulting in coercion of residents. I can honestly see staff saying, "Sure, I'll buy you a carton of cigarettes. You can have your"—I don't know what a carton of cigarettes is now that the price has gone down: \$25, let's say? "Sure, you can have your carton of cigarettes. You give me \$30." As Mr Carrick said, I can also see residents doing that to other residents.

I can see you wanting to control the sale of tobacco products to minors, but you're not dealing with minors here. You're dealing with a population that doesn't have a lot of resources to get out and go to the corner store. As Mr Carrick pointed out, in some instances it might be quite dangerous for them to try to go to the corner store. You also have to think not just of the homes that are at the corner of Sherbourne and Wellesley but the homes that are out in the country somewhere where there is no corner store around.

I couldn't say for sure in terms of statistics, but I think that generally speaking the percentage of residents who smoke might be lower than the percentage of people in the general population who smoke, and this has probably come about simply because a lot of them have a very limited amount of money and they've had to give up smoking because they can't afford it. But I think you should give serious consideration to allowing the sale of tobacco products in long-term care facilities to residents.

**Mrs O'Neill:** We've had a very similar presentation from the veterans, and I've had a lot of correspondence

from various homes for the aged on the issue.

I'd like you just to clarify for me, at the present time the homes for the aged are governed both by the directive that came from the Ministry of Health and then by the municipal bylaw in most instances. Is that correct?

**Mr Carrick:** We are subject to both of those regulations, those official bodies. This renovation I spoke of a short time ago was a directive from the Ministry of Health of Ontario, and all the homes have adhered to the renovations as required.

**Mrs O'Neill:** This does make this bill rather contradictory to a relatively new directive. I'm glad you brought that to our attention.

At the present time, are the homes for the aged that have a facility for sales limiting the sales to the residents?

**Mr Carrick:** Yes, that is the way it remains at the moment. We do not allow sales to outside persons and we don't have minors in the building anyway.

**Mrs O'Neill:** The designated smoking areas then are the only area in the facilities where there's smoking permitted? There's no smoking in the individual rooms, even if they're private rooms. Is that correct?

**Mr Carrick:** That is very correct, and that is governed by the Ministry of Health and the fire departments. We allow only the designated areas in which to smoke. Any other area, including the workplace of the staff, is limited.

**Mrs Haslam:** Just to reiterate that fact, you have non-smoking common areas?

**Mr Carrick:** Yes, we do as well.

**Mrs Haslam:** Some of the other products that people in long-term care facilities receive, chocolate bars and soaps and other sundries, where do they obtain those?

**Mr Carrick:** That is in the gift shop that each home maintains. They have all of those minor desires, and they do have quite a reasonable intake each month, which is turned back to the residents' funds themselves. While it is not a highly profitable organization, it is one that does benefit the residents themselves.

**Mrs Haslam:** I think the concern I'm beginning to see out of today is that everyone says this legislation's great except don't do it to the students' area, don't do it to long-term care facilities, don't do it to pharmacies, make an exemption in a psychiatric hospital. The next group I'm sure will come and say, "Make it an exemption in a regular hospital, because if you're on crutches, you can't get downstairs."

I think the concern is looking at the term "health facilities," and the idea of leaving the option for one or two leads to five and six exemptions. I think that's my concern when I hear, "This is a good bill, but add us to the exemption list." That's all I had to say.

**Ms Glover:** I think in looking at long-term care facilities, perhaps we should not be looking at them as health care facilities but as the home of the people who live there.

1140

**Mrs Haslam:** Would you consider the home then to be their rooms?

**Ms Glover:** No, I would consider the entire facility to be their home.

**Mrs Haslam:** We've also had a presentation from people who live in apartments, basically seniors' apartments, who came before us asking us as a provincial government to outlaw smoking in the lobby and in the common area downstairs because there are many seniors with asthmatic attacks. There are many seniors who are kept in their rooms because they cannot go downstairs through the lobby or through the lounge area where there is smoke. The other side of the argument was there versus this side of the argument.

**Ms Glover:** Smoking in long-term care facilities is very tightly controlled, as Mr Carrick said. There's very limited space for residents to smoke, and people who don't smoke and don't want to be exposed to smoke are—

**Mrs Haslam:** And what we're looking at is the sale of tobacco.

**The Chair:** Final question, Mr Eddy.

**Mr Eddy:** Thank you for your presentation and coming forward to the committee on behalf of all the residents or homes for the aged across this province, because it's very important. Unlike Ms Haslam, I am not afraid of the exemptions. You are adults using a legal product. You have the right to do that and you have the right to do it in your homes, and those are the homes for the aged. The forcing of the separated smoking areas is right and proper, because that keeps smoking from people who don't want to be involved in it and don't want to smoke. So it's right on.

It's still a democracy, and I very strongly say to you that if this province had done something about the contraband cigarettes instead of worrying about some of these things, we'd be in a lot better position today. But I want you to know I support your request. I'm not afraid of the exemptions.

**Mr Carrick:** May I make a closing note? I do appreciate your support, sir, but I do feel that having dictated along these lines that smoking is to be prohibited here, there and everywhere is certainly an infringement on my civil liberties and I feel it is contrary to our Canadian Charter of Rights if you would.

**The Chair:** Thank you both for coming before the committee this morning. We appreciate your presentation.

WOBURN COLLEGIATE INSTITUTE

**The Chair:** If I could then call on Mr Gary Pennington, vice-principal of Woburn Collegiate Institute. Welcome to the committee. Have some water. Once you're settled, please go ahead with your presentation.

**Mr Gary Pennington:** I guess I represent the other end of the spectrum to the previous speaker. I work with people I think the act is designed to help, from 12 to 20 years of age, very vulnerable years. Many of you are parents of teenagers. You know many teenagers have this idea that they're invulnerable. This morning I had a pregnant girl in my office who is all of 15 and is a smoker and knows nothing about these health issues, in talking to her.

I wanted to make the point as a vice-principal, on



behalf of teachers, that this is a progressive piece of legislation. I want to encourage it and I want to commend the government for bringing it forward and I don't think it goes far enough.

In my 30 years of working with teenagers, I have seen a dramatic decline in the smoking by them. I work for an employer that has a workplace ban on smoking and has had for over five years. There are no problems with that. Just this morning I asked a smoking staff member how she had adapted to that. She says she goes for fitness walks to have her smoke, something she didn't do before. I thought, that's the kind of adaptation they did after the initial grumbling.

As you know, schools do a number of things educationally to pass on information increasingly coming out of the research establishment to people like this pregnant girl this morning. Some of the things we do, which you may or may not be aware of: We have public displays. Public health nurses come in two or three times a year and set up interactive displays that are quite popular with the teenagers. We have anti-smoking information in all health courses. We have smoke-free weeks in which we give out free carrot sticks in the cafeteria and put on contests, give it a fun aspect.

I think there's modelling by staff. There are 130 teachers on my school staff, and less than 5% smoke. They're not afraid to make that comment to students about the modelling and the importance of their leadership for young people.

Of course we don't have any sales in our cafeteria. One of the things that has changed in recent years is that we don't allow smoking at evening dances. That's something that has happened.

I'm aware as I walk up the front walk of my school, which rents out to public facilities in the evenings and weekends, it's littered with cigarettes and cigarette packages. It's a small point, but we've had our caretaking staff cut by 25% in the last year through the social contract and other cutbacks of funding, so the cleanup doesn't happen as fast. The chief caretaker has a real problem keeping the appearance and the tone that we want to promote in our high school, which we're very positive and proud of. There are lots of different spinoffs there.

I did want to say something about the workplace ban, which I'm in favour of. I think it works. The smokers have adapted to it, and there's been a dramatic decline.

One aspect of my presentation and research for today was that we checked with some of our grade 9 students about where they buy cigarettes. There is a retailer within a couple of hundred yards of our school, a convenience store, who will sell them cigarettes. We asked our foot patrol, assigned officers from the Metro police, to visit this man. He said, "I admit to doing it and I'm not going to stop." That was the end of that. One of the reasons he gave was: "I can't afford to do it. I don't have insurance, and they'll vandalize me if I don't sell to them."

We know they're getting access to it within close bounds of the school, but the designated smoking areas, which we tried in high schools, which I heard referred to

by previous presenters, did not work for us.

I also worked at the faculty of education, which had a designated smoking room as of last fall and then eliminated it. I taught across the hall from it. It was an unpopular place to teach, because every time the door opened, you would smell this waft of smoke and chemicals coming into our room, so nobody wanted to take that classroom. That particular designated smoking area was a disaster for the young adults which I heard the students' association refer to. That has now been eliminated, and people adjust.

I think the climate of parents and students in high school who I work with every day is very positive to this pressure and support, education and enforcement balance that I think is happening. I want to commend you for the act. I don't think it goes far enough, but that's my perspective.

**Mr Owens:** Mr Pennington, thank you for your presentation this morning. While your colleague is not in my riding, I represent the riding of Scarborough Centre and I subscribe to your views completely.

This hooey and hot air about civil rights and the right to smoke and all that other stuff that I've heard—and this is my first day on committee—I find quite disturbing, because we control other legal substances, like alcohol, like the right to drive. We control other aspects of social behaviour, so all of a sudden the right to smoke and the right to cause other people health problems is a little bit bizarre, in my thinking.

I think that clearly you're on the right track in terms of the education and enforcement issue, particularly with students in grade 9. You're absolutely right, they're at that prime age for peer pressure and all the other social pressures kids have, particularly now. I try to tell myself I'm not that far away from that age, but every year it gets farther away. There needs to be some level of support from the school system and from parents to ensure that they don't get involved in a habit that has been determined to be detrimental to their health. So while I don't have a question, I appreciate your presentation.

**Mr Sterling:** I was very much interested in your remarks. Having tried to ban smoking from all schools during the last Liberal administration and being unsuccessful in doing that, I'm glad they're doing something in this bill regarding smoking in all schools.

**1150**

You should know that the workplace legislation that we have in place in this province is not all that strong, and many of the advocates coming from my end would have liked to have seen this government strengthen the workplace legislation. It's also happening in some jurisdictions that I represent, the city of Kanata in eastern Ontario, that municipalities are seeking the right to stiffen the provincial laws which are in place. A lot of municipalities feel that the laws are weak in that regard.

You mentioned that you would like to see some additional measures taken. Have you any ideas in that regard? You say this bill doesn't go far enough as far as you're concerned. Do you have any other suggestions?

**Mr Pennington:** My understanding is that it doesn't

deal with a workplace ban.

**Mr Sterling:** That's right.

**Mr Pennington:** That's why I want to give an example of working for any employer for five years who adjusted to that. Because there was an outcry initially that this wasn't going to work, it was unfair, undemocratic, all of the arguments we've heard. Five years later it's working extremely well, and staff members have told me it's an encouragement and support for them to stop.

As a vice-principal, I had to enforce this double standard of allowing staff members to smoke in the staff lounge, yet 50 yards away, students caught got an automatic two-day suspension. It was a double standard that kids will throw up to you very easily. Once that was brought in, it made it a lot easier, and I think that's one of the reasons smoking has fallen off in and around high schools.

The areas where they still smoke, just over the property in a public housing apartment parking lot, that's where they go and it's also the most vandalized area of the whole community. The students I deal with often have problems, either psychological or attendance or academic problems. I've been taking little, informal surveys as I talk to students every day in my office. Almost invariably those students are smokers.

I gave you that example this morning which happened at 9 o'clock. I'm talking to this girl, she is so vulnerable and her baby is so vulnerable to this ignorance that I just felt I had to say that this morning, that you're on the right track for this generation and the succeeding generation. As you can tell, I feel pretty strongly about this. I have a daughter who smokes, and that's a real concern to me as a parent.

**Mrs Haslam:** That's what I wanted to talk to you about, the message to youth, because it's a concern of mine. One of the things that I've been collecting over the process of this committee meeting just adds fuel to the fire, and I want to ask you a question. I have an 11-page document that lists the chemicals in cigarettes, 11 pages of chemicals, one of them being Varsol, one of them being toilet bowl cleaner formula.

We have seen advertisements—in American magazines, I will admit—but advertisements that say, "I always take the driver's seat. That's why I'm never taken for a ride," unless you're being taken for a ride by the tobacco manufacturers; or "If you always follow the straight and narrow, you'll never know what's around the corner." That's because what's around the corner is cancer.

I have a concern about this type of marketing and I came across some documents that showed that the tobacco manufacturers, in some of their marketing documents, had targeted young people. I wonder if that kind of information—because young people hate to be used and they hate to be made fools of and they hate to be looked at and told, "You're being used by a media firm."

Would that kind of message be what assists us to reach the young people since the education of—and you're right: "I'll live for ever. I'm 15. Don't talk to me about cancer of the lungs. Don't tell me about the man who lost

his tongue. I'll live for ever." Is this kind of message more attuned: "Don't be a sucker, don't be used"? Is that the kind of message that education should be looking at now?

**Mr Pennington:** I think you're on the right track with that. When you say that, I think of the ads now running in the theatres, the commercials, which are Ontario government commercials. They are very powerful for teenagers, who tend to go to movie theatres, I think, in much greater percentages than the adults; at least, that's the impression I have. My daughter, who is 19 and a non-smoker, has commented on the power of those ads in dramatically speaking to them. From that little informal survey, I would say we're on the right track with that type of dramatic approach.

**Mrs Haslam:** If we're on the right track, would limiting the access to tobacco outlets be another goal we should be looking at?

**Mr Pennington:** I think so. Not that I'm a great expert on this, but I have the closest retailer to us saying, "I'm not going to stop. I admit to doing it."

**Mrs Haslam:** If he lost his right to sell tobacco?

**Mr Pennington:** I think that kind of enforcement seems to work in other areas of the culture. Why wouldn't it work in this part? A visit by a policeman had no effect, so I think yes, you have to look at that.

**The Chair:** Final question, Mr Eddy.

**Mr Eddy:** Thank you for a very strong presentation expressing your concern about smoking among our youths, because it is a very serious matter. There were a couple of things I wanted to follow up on, and I particularly note your point of non-enforcement of present laws. If we have more laws, new, stronger laws, we can only hope that there will indeed be strong enforcement; at least some enforcement. It's a shame there isn't.

I thought you said about the 15-year-old student that she did not know or realize the bad effects of smoking. Then you went on to say there were some demonstrations at the school about the effects of smoking. I was greatly disappointed in that statement. Surely she would be exposed to information about the bad effects.

The other thing I wanted to ask about, if you would, how far would you go with preventing smoking? Would you go as far as a complete ban on tobacco products, realizing, of course, that some people do smoke heavily and are addicted and there would have to be some system to allow for some smoking? Where would you limit tobacco smoking to? Homes only? How far would you go?

You've mentioned smoking in the workplace. I agree with you on that certainly. It's not strong enough and it's not being enforced, but how far would you go?

**Mr Pennington:** It's a good question. I don't have the answer.

**Mr Eddy:** I know where I would go, but I'm too strong on it.

**Mr Pennington:** One of the things we're operating in our schools these days from the Ministry of Education is a phased-in change over three years to our grade 9



curriculum. That seems to be an approach that I think has a lot of merit, a phased-in approach where you state the goal of where you want to move and you allow people time to adjust to it. The teaching profession is adjusting slowly and surely to what I think are progressive changes in the grade 9 curriculum.

So that phased-in approach has a lot, but I think the government needs to state clearly that we want to move towards a smoke-free society. A clear message of that and how you work in the timetable I think is up to your own wisdom and enforcement feasibility, but I think that clear message needs to come out for teens.

I don't know how that girl escapes, because there is one compulsory physical education course I'm sure she's taken. She's not a unintelligent girl, but she's wrapped up in trauma in her life. In questioning her I said, "Are you aware of any of the latest research coming out about the effect of smoking on foetuses, just noted in the paper this week?" She said: "No, sir. I don't know anything about that."

That's the kind of vulnerability that I think your legislation deals with. When I listened to all those previous presenters, I was thinking, "Wow, who's speaking for these vulnerable people?" It's great to hear from university students and old-age homes, but doggone it, teenagers are very vulnerable. But they will not admit their vulnerability.

I just think you're on the right track, and I'd like to see that as a statement come out of government, that we are moving towards a smoke-free society. There are lots of positive examples of how to do this. As I said, I've seen it in schools. Smoking did decline.

**Mr O'Connor:** I just wanted to add a clarification for the record. Perhaps some of the members may not be aware, Mr Eddy raised the issue of enforcement and, of course, that's something we're all very keenly aware of. The Minister of Health yesterday made a public statement that there will be \$2.5 million put into the hiring of an additional 50 public health inspectors to deal with the enforcement. I just wanted to put that on the record.

**Mr Pennington:** But it has to have more backup, because we already sent an enforcement figure, and the retailer said: "So what? I'm not going to change."

**Mr O'Connor:** It's there.

**The Chair:** Mr Pennington, thank you for coming before the committee and for your presentation.

The committee is adjourned until 2 o'clock.

*The committee recessed from 1200 to 1400.*

#### HAMILTON-WENTWORTH COUNCIL ON SMOKING AND HEALTH

**The Chair:** Our first presenters this afternoon are representing the Hamilton-Wentworth Council on Smoking and Health, if they would be good enough to come forward and introduce themselves. It always sounds like we're about to start that old TV program, What's My Line? Somebody came in and you'd write your name on the board.

**Mr Carr:** Who remembers that show?

**The Chair:** You see, I keep demonstrating my age.

**Mr Eddy:** It was before my time.

**Dr Barbara Gowitzke:** Mr Chairman and members of the committee, we're grateful for the opportunity to be here today. My name is Dr Barbara Gowitzke. I'm the president of the Hamilton-Wentworth Council on Smoking and Health. Accompanying me is Mrs Anne Washington, who is the chair of our education committee for the Hamilton-Wentworth council and also the health education coordinator—prevention, for the Lung Association Hamilton-Wentworth.

We have provided you with a brief, on page 2 of which is a summary of the major points, so that you can follow along.

Talking to the major point, the first and most important point I'd like to make is that there is a basic premise that it is important for the standing committee to accept. The standing committee needs to send a clear message to the Legislature by strongly supporting the Tobacco Control Act.

The Hamilton-Wentworth council believes that the committee can do that if each and every one of you accepts a basic premise; that is, if each and every one of you accepts the preponderance of research studies which have shown that tobacco is the leading cause of preventable death in Ontario. In fact, tobacco is the only legal consumer product that kills when used exactly as intended. The standing committee must also recognize the agonizing months and years of pain and suffering which precede these deaths. Financially speaking, the concomitant health care costs to the province are colossal.

With regard to the Tobacco Control Act, the Hamilton-Wentworth council supports and commends the government of Ontario for introducing this important piece of legislation. The council applauded the Ontario government's strong resistance to tax reduction and recognized that the federal government placed the province between a rock and a hard place. But now we have a major problem.

Bill 119 has many strong points and this council is particularly supportive of sections 4, 5, 6, 7, 9, 10, 11, 13 and 14. But in the light of recent events, it is now imperative that this bill be strengthened. Tax decreases mean increases in consumption, especially for young people, which is totally contrary to the spirit of Bill 119.

Our recommendations are as follows:

First, amend the bill to require a retailer licensing system. Do this either by licensing outlets as we know them today or by instituting an LTCBO, ie, Liquor and Tobacco Control Board of Ontario. The council favours the latter plan. Enforcement officers have shared experiences with us which suggest that only with small and limited numbers of retail outlets can we effectively control the sale of tobacco to minors.

Second, require generic cigarette packaging. In any comprehensive plan to address the tobacco epidemic, generic packages or at the least plain packages must be at the top of the list. Attractive and colourful packages give kids an enticing symbol which represents the critical passage from adolescence into the world of adult behaviour. Research shows that kids are turned off by plain

packs. A recent study concluded that plain packaging would break or substantially weaken the link between the package and other promotions.

The most prominent way in which tobacco products are now promoted is through sponsorship of events like jazz festivals, tennis tournaments, fashion foundations and car races. By connecting advertising for such events with the colours and designs used on tobacco packages, the industry effectively promotes its product.

Third, adopt a reverse onus philosophy to legislation, such as that used in Finland. The legislation is based on the premise that all non-residential places are required to be smoke-free unless the contrary is indicated by "Smoking Permitted" signs. This blanket prohibition clearly enunciates a public health policy which condemns environmental smoke as a health hazard. Such an approach requires that applications for smoking-permitted venues would be made and only those meeting certain well-defined criteria would be granted.

Once again, in light of the recent tax reduction, it will be important to have a strong public places policy to protect the non-smokers. Let's face it: Tax reductions lead to more smokers, which will in turn lead to more smoking in public places and more involuntary exposure of non-smokers, and smokers too, to secondhand smoke.

ETS is the insidious disease. The smoker is the carrier. People exposed are often unaware of their exposure and the seriousness of the disease. It's rather like being exposed to radiation from the sun; you don't feel it or notice it until it is too late. I bring to your attention something I don't have in my brief from yesterday's paper. Canadian scientists yesterday reported finding evidence of cigarette smoke in foetal hair, the first biochemical proof that even the offspring of non-smoking mothers can be affected by passive cigarette smoke.

Fourth, and finally, create a smoke-free environment in all workplaces in the province. This is a critical need and should be done as soon as possible by adding a section to Bill 119 which would ban smoking in all workplaces. Just as a reminder, one person's public place is usually another person's workplace. At the moment, most Ontario municipalities have no such power to enact such legislation. It means that the only body in a position to control smoking in the workplace is the provincial government. This is needed now, particularly in light of the provincial target of smoke-free workplaces by 1995.

Finally, enforcement: It's key to Bill 119. All of the education and legislation attempts at federal, provincial and municipal levels still fall short unless there are some teeth in the system in the form of enforcement. I welcomed the minister's announcement the other day in Barrie.

In conclusion, the Hamilton-Wentworth council believes that incorporation of the above suggestions into the Tobacco Control Act will make this legislation one of the strongest in the country, will take some of the sting out of the reduced prices and will reinforce the comprehensive tobacco control program now being implemented by the provincial government. Equally important, passage of this act will underscore the government's commitment to preventive health care.

Now, if I may, I'd like to turn the attention to Mrs Anne Washington, who will speak on behalf of the Lung Association.

**Mrs Anne Washington:** Thank you, Barbara and members of the committee. I raise my glass to the province of Ontario for having moved as far as it has with tobacco legislation. Congratulations.

**The Chair:** We hope the water is good.

**Mrs Washington:** Indeed. I just want to set into a framework for you a little the reason why I'm here today. For the past eight years, my professional life has been entirely devoted to tobacco use prevention, cessation and public policy in the schools community and within the six municipalities of the Hamilton-Wentworth region. Rather than make a separate presentation from the Lung Association Hamilton-Wentworth, we agreed that we wanted to show our concern and our support of the work of the Hamilton-Wentworth Council on Smoking and Health. In that regard, I'm here today in support of the brief that Barbara has presented for you.

In Hamilton-Wentworth, we work as a team on the tobacco issues. We are a concerned team and why we're here today is to ask you to be a partner in this team so that we can improve the health and wellbeing of every member of the community of the Ontario province.

To give some sense of what it is that those with whom we are doing this bill feel about this, I bring today the voices and the concerns of our most precious resource: our children.

I have seen the addictions of an 18-year-old and a 15-year-old as they struggle with tobacco use. I have seen the frustrations of asthmatics who are caught in a situation where they no longer are able to breathe clean air because other people choose to smoke. I have heard the frustrations of people in workplaces who say, "We need to have stronger legislation so that we can bring in total bans."

Let us turn for a moment now, if we may, and let's just listen to those kids and see what they've got to say to you today. Would you roll that tape, please?

*Video presentation.*

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**Mrs Washington:** To support what those children, who are enriched students, say—they wrote the words for that; it was not a put-on job—I have brought these for you, if the clerk would distribute them, from that junior-level school. Also, a grade 11 student has taken the time to write you a two-page letter. His interests concern no smoking on school grounds and vending machines.

I have also brought along for you today a feeling from grade 1 students—the mood out there is to do something about tobacco; grade 7 students; and a petition after a two-week series on tobacco use prevention and cessation from the students of a middle school. These students became so actively involved in this issue that they chose to write to you:

"We, the staff and students of Westview Middle School, would like the Ontario government to be responsible and to pass legislation that will protect the innocence of children from the insidious impact of this



addictive drug, nicotine." The petition has been voluntarily signed by the students with the full knowledge of their parents. I'm going to ask Mr Larry O'Connor if he would submit this petition to the Minister of Health for us.

I've taken a few minutes to share some material with you that comes from the hearts of young children. What you are doing here today and what you will recommend to the government of Ontario is of vital importance. You have a part to play. All we can do is to give you some input and hope that you will listen. Thank you for your time.

**The Chair:** Thank you for your presentation. I think it's safe to say we have not had as unique a presentation with the young people as you've presented and we appreciate that. It struck me, just in terms of your brief, that the young people were in the drawing of course using the advertising, albeit they were working out their own name, but just the way in which that plays in the marketing and how significant that is for them. So it's sort of recording some of the things you were saying. We'll move to questions then. Mr Carr.

**Mr Carr:** Thank you very much for the presentation. How old were those children?

**Mrs Washington:** Those children were grades 4 and 5. They would have been 10 and 11, but they are enriched students.

**Mr Carr:** I was thinking the same because my son's in grade 6 and he's 11. He's also in enrichment classes, and they did look the same age.

With regard to the overall dealing with this whole issue, as you know, Bill 119 has taken a step in one direction, but within the last week or so we've probably taken a step backwards with the reduction in the price. How much of an impact do you think that will have in terms of what goes on? I suspect that with young people the cost is a big factor. I asked a couple of the young people up in Thunder Bay. They said they'd somehow find it regardless of the price. With the recent changes in the cost of tobacco, what do you see happening in terms of the usage among our young people?

**Dr Gowitzke:** We've both seen it; maybe both of us should comment. Just doing sort of an informal survey with some teachers in one of our schools in the east end, we've already had reports that it's a little bit like the forbidden fruit and they couldn't wait to get out of school the day that the prices went down to buy their cigarettes. Mrs Washington also has comments.

**Mrs Washington:** You'll notice if you look at the price sensitivity of children, which is two and a half times greater than that of adults, that definitely this is going to have an impact. James Dietrich, the grade 11 student, has taken great pains to draw your attention to what he has seen and what he feels about that issue. So, yes, it is having an impact. I have heard it in the schools where I have been and I have seen it even this morning, when students were purchasing cigarettes.

**Mr Carr:** It's my feeling that this bill, although a good intention to stop the issues, I think we're going to be behind overall because of the reduction. So we've taken one step forward and two steps back. What's your

reaction? Is this just going to help nullify the increase, or are we going to be actually farther behind today than we were three months ago?

**Mrs Washington:** We've moved backwards but we mustn't be discouraged by that. What that tax rollback means is that Bill 119 has to be even more strengthened, particularly through plain packaging. We know very well that kids are influenced. How do I know? The cigarette that bears the lipstick traces bears the responsibility for children taking on this particular addictive substance. Plain packaging is vital to help combat that rollback on taxes.

**Mr Carr:** Good, thank you very much. Good luck with your fine work.

**Mr Haslam:** I was reading the letter from the grade 11 student. You're correct: He is very clear in saying, "I've been buying them since I was 11 and nobody's asking my age." He feels the price is going to be a very strong enticement for young people. Everything is all connected in this legislation when you look at vendors who sell to minors. We're trying to find a way to stop that.

One of the ways we have looked at in this legislation is the model we've put forward regarding when a vendor is caught selling to a minor. If it's twice within a five-year period, they lose the privilege of selling tobacco. They must post a sign stating they've lost the privilege. The signage, to me, is a very important point in the business. The manufacturers and the providers of it are also made aware that that store can no longer sell tobacco plus, apparently, they cannot even have tobacco on their premises.

Having said that, having looked at those types of deterrents, plus the additional 50 inspectors that Minister Grier has just announced, my concern is holding up the legislation or putting in place a licensing system versus getting this type of system going very quickly as what is proposed in the legislation. Are you still in favour of going into a licensing versus this type of system, and why?

**Dr Gowitzke:** If I can respond, I'm still in favour of going to a licensing system. What you described is perhaps somewhat of a deterrent for some, but I guess—the words that come to mind—it's still "Mickey Mouse" as opposed to having some real teeth in the system. As you heard me say, we're really in favour of, if anything, limiting the number of tobacco vendors and taking it to the LCBO.

**Mrs Haslam:** That has been suggested. What do you see as the difference between losing the licence and losing the permission and signage, losing the right to sell tobacco? What do you see as the difference other than this system of licensing versus not licensing? What's the difference between you can't sell tobacco for six months and you must put a sign stating that versus you've lost your licence to sell tobacco for six months?

**Dr Gowitzke:** I guess they both come out with the same result, but 50 inspectors across the province of Ontario aren't going to catch them all.

**Mrs Haslam:** That's another concern about the

expense of licensing versus this type of system. I myself would rather see the money go into enforcement.

**Dr Gowitzke:** Do you have a comment?

**Mrs Washington:** Yes. I think there is an obvious need here for massive education of retailers. That's one component. We haven't time to get into that.

I also see that licensing will to some degree be self-regulatory. One person who loses a licence will be a clear indication to others that if they continue to sell tobacco illegally, their licence will be removed. Whichever route you take, we need to do something very soon, because children are accessing those tobaccos.

**Mr McGuinty:** Thank you both for a very interesting presentation. I just want to comment briefly on the issue of the tax reduction. I think all of us had some serious reservations about that, but it's certainly my hope that the impact of that reduction will be to drive sales off the streets, out of car trunks, out of school yards, into stores. Hopefully, with Bill 119, it'll be impossible, first, for young people to acquire their cigarettes from retailers.

An idea that's been tossed around here from time to time is everybody's concerned about the mixed message when it comes to cigarettes. You've got adults smoking. We're telling kids that they can't smoke.

It's interesting, you gave us this chart here, the causes of preventable death. I've heard about that before but it's great to have it in chart form. Tobacco deaths far exceed what looks like all the others put together here: alcohol, suicide-related, traffic, falls, AIDS, drugs, poisoning, drowning, homicide, fire.

It's interesting, when it comes to alcohol, we tell our children it's illegal for them to drink. When it comes to a new law which is going to make bicycle helmets mandatory—and I think we may have around 200 deaths a year in the entire province when kids are involved in fatal accidents, head injuries related to when they're riding their bicycles—we're going to make it illegal for them to leave the house without their helmet.

I think there's a message involved in being able to tell kids that something is against the law, so I think we've got one end of it worked here. We're telling retailers, "Look, it's against the law," but we can't tell our kids, "You know, it's against the law for you to smoke." If I have a 14-year-old or 15-year-old who's smoking, I think, and some parents and teachers and medical people have told us this on the committee here, it would be nice if they could tell kids, "It's against the law." What do you think?

**Dr Gowitzke:** You've hit a very sensitive point with me, Mr McGuinty, because for some time now I've been concerned with the fact that with all the municipal and all the provincial legislation, or federal legislation for that matter, in the world that controls the vendors, you're still not going to do anything about those who actually possess tobacco.

In Hamilton-Wentworth, we've talked with our police services board about enforcement of the law with regard to possession and we're told by them that they have other more important things to do; murder, suicide, drugs and alcohol capture their attention. I guess it's for the reason

that I mentioned in my brief. Those are more dramatic, you know, here today, gone tomorrow; it takes 30 years for tobacco to kill you.

But you've hit a very important and sensitive point as far as I'm concerned. Maybe some of those 50 health inspectors will do something about enforcement in that regard.

**Mrs Washington:** I think if I might make just a brief comment, from the background experience I have in the schools, this has to be a comprehensive approach. It has to happen at home, it has to happen in the schools, it has to be seen by the actions that our government takes. It's a health, it's a political, it's an economic issue, and everybody has to do their bit towards it. It's tremendous how far the Ontario government has come. I believe they're going to stand firm and I really believe they're going to go further.

**Mr McGuinty:** I'll look forward to that.

**Mr O'Connor:** I just wanted to put on the record my thanks for the day I had with this committee in Hamilton. I think with all the hard work that you're doing out there and the legislation and the approach—the media have been good in keeping this as a forefront issue—because there are so many people who die prematurely because of tobacco-related illnesses, I think we're going to go milestones. I want to thank you for your ongoing effort.

**The Chair:** Thank you for coming today.

#### CIGARETTE VENDING MACHINE OPERATORS AND DISTRIBUTORS, NIAGARA SECTION

**The Chair:** I call on Mr Ron Kane, Mr Raj Asser and Mr Bruno Monaco. Gentlemen, welcome.

**Mr Ron Kane:** We represent the Niagara section of the Cigarette Vending Machine Operators and Distributors. We've already had one casualty in the Niagara region. A cigarette distributing company has closed its operations in St Catharines. This is one less business contributing tax dollars. Some of the remaining operators will declare personal bankruptcy and lay off employees if Bill 119 is passed as proposed.

There are about 6,000 cigarette machines in Ontario. Tobacco manufacturers reported total revenue of \$10 billion; \$76 million of that amount was from machines in Canada; \$29 million was generated through machines in Ontario. The province of Ontario earned \$2.15 million in taxes in 1991. Less than 1% of all legal cigarette sales are from vending machines in Ontario.

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"If they're under age they're not betting legally—but they're buying a legal product" Floyd Laughren said in January regarding Pro Line lottery tickets purchased by teenagers. Can we use the same quote on cigarettes? The government lottery machines are placed next to our cigarette vending machines with stickers, gold and black, which read, "Children under 18 not allowed to use this machine." If that is an acceptable monitoring system, can we use the same? We cigarette vending machine operators are selling a legal product plus paying PST and all the other taxes associated with it.

We're not in favour of teenagers smoking. We're here



to convince you that the cigarette vending machines are not being used by children. "Over two thirds of smokers buy their own cigarettes...from corner stores. Other places where individuals reported buying...cigarettes" are "doughnut shops, gas stations, restaurants, pool hall, bakery and duty-free from the United States." From the Canadian Cancer Society, *Effects of Plain Packaging on the Image of Tobacco Products Among Youth*, page 11.

We support that. Andy Barrie of CFRB conducted a radio talk show with teenagers. It was an open-line phone-in show. Not one teenager present at the station or the ones who phoned in said that they used vending machines. All used corner stores. They walk in and get served with under-the-counter cigarettes. This has changed recently, but through nobody's fault.

The parliamentary secretary of this committee asked the question of the school children of York region on Thursday, February 3, 1994, if they or other children are using vending machines. One child said she did when her father asked her to get him a pack. The catchphrase here is that her father asked. Parents have some responsibility too.

All the research shows that cigarette vending machines are not children's enemies. We are being victimized. In a 15-minute script we cannot present audio-visual, but we suggest the committee get these from CBC radio and television, CTV and CITY. As the Minister of Health put it, when some of the retailers will not be selling the cigarettes over the counter, the children will start using vending machines, so ban the machines. There was no study done on the cigarette vending machines and their use by children. If a child cannot buy from a drugstore, is he going to look for a vending machine or is he going to go to the corner store that's open all hours and sell cigarettes substantially cheaper?

"Tobacco consumption will rise this year for the first time in a decade as smokers take advantage of cheaper cigarettes to puff harder, says a federal official."

**Mr Anthony Perruzza (Downsview):** Shame, shame.

**Mr Kane:** St Catharines Standard, December 21, 1993. Yes, it is a shame.

"Pierre Villeneuve, an aide to Health Minister Lucienne Robillard, said that almost all youths who now smoke buy their cigarettes on the black market." St Catharines Standard, February 2, 1994.

All the information we are getting is that the minors are smoking because of the easy access they have to the black market. Cigarette vending machines have been here long before this increase and there was a steady decline in smoking.

We ask you, elected members, why is the quote "small businesses are the backbone of our economy" not given any importance as soon as the elections are over? When the loonie was introduced we were put in the position of converting our coin mechanisms at approximately \$750 per machine. We have not finished paying off these conversions.

The average age of our operators is in excess of 50 years. These operators will not be entitled to UI benefits, and by facing bankruptcy will not have the means to

retrain or start other businesses. We have hundreds of thousands of dollars invested in our business. If we are out of business in three months what are we going to do with these machines?

What do we do after we go broke? Anyone out there looking for ex-business people? Maybe this government wants more on welfare. When the GST was proposed, the labour groups warned the government the GST will take the economy underground. We urge the NDP government not to pass Bill 119 as it is; otherwise the contraband business will flourish in Ontario.

The campaign is aimed at saving lives and cost to our health care system.

"Illness due to unemployment—everything from stress-related headaches to heart troubles—cost Canada's health care system at least \$1 billion last year, a new study suggests.

"Unemployment causes human suffering and places a heavy economic burden on the health care system," said Dr Shah, co-author of the report and a member of the public health committee of the Ontario Medical Association."

All of our group are already suffering from the stress of our situation, as you can tell from my reading here, not knowing where our future lies, or more important, do we have any? This province has no control over most of the job losses and further burdens to the social programs. It does have a choice at this time in choosing not to put us out of business and on to the welfare rolls, as we have shown sufficient evidence that vending machines are no threat to the teenagers.

It is discriminatory to ban cigarette machines, because the government is allowing cigarette vendors to continue selling cigarettes. There has been no mention of compensation to families who have started and operated vending machine businesses, investing all their savings to sell a legal product. You are violating our constitutional rights, denying us the right to earn a living, at the same time allowing this legal product to be sold in corner stores.

"New York state passed a law in April that banned cigarette machines throughout the state—with the exception of fully liquor-licensed establishments.... New York City went to court to keep the '25-foot rule.'" That means machines located inside licensed establishments of 25 feet. They lost that. That was reported in *Vending Times*, December 1993.

We recommend that you give legal responsibility to children and their parents, that government continue with its education programs and that you apply with force the existing laws. I was buying cigarettes when I was 10 and 12 years old in Toronto and no one ever questioned me and it was the law in fact then. It's never been enforced, at least not to my knowledge.

What steps are being taken by the Ontario government to prevent smuggling? For that matter, if you make the law 19, what's going to stop the other kids from selling the singles to the kids in the schools rather than the packages?

Will we be compensated? Why do pharmacists get one year to adjust their business and the cigarette machine

operators three months? Thank you for your time. If you have any questions I'd like to help.

**Mr Owens:** Thank you for your presentation. You mention by way of example some of the US jurisprudence with respect to the amount of distance between I guess the front door and where a cigarette machine can be located. Are you aware of any Canadian jurisprudence on that issue?

**Mr Kane:** Not that I'm aware of.

**Mr Owens:** You ask the question specifically with respect to an adjustment period. Are you suggesting that if the ministry was amenable, you would agree to a one-year period to withdraw from the business?

**Mr Kane:** Would you agree to the disposing of your whole business in a one-year period? I don't think anyone would agree to that. I think the federal law has approached the thing from a reasonable standpoint. Cigarette machines are legal in licensed establishments according to the federal law as of February 8.

**Mr Owens:** In terms of the issue with respect to enforcement, we were clearly forced into a situation by the federal Liberal government, but I can assure you that what our Solicitor General was doing with the now deceased Conservative government was arguing strenuously for enforcement of anti-smuggling laws, which as you say currently exist. You shouldn't have been buying cigarettes at 12 any more than a 12-year-old at this point should be buying cigarettes, and enforcement is clearly an issue that we take quite seriously.

I'm sure the parliamentary assistant can wax poetic about the good things the ministry is proposing to do. The issue that I have some concern with is access to the product. Yes, it is a legal substance at this point, but as I said this morning, there are a number of substances and social things that the government regulates.

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This is my first day on the committee. I was given today an 11-page document with the numbers of chemicals that are in cigarettes, and I'm suggesting to you that while it may be a legal product, in fact some control is necessary in terms of trying to mitigate the kind of damage that we're seeing now because of the number of years that the people have been smoking, and what we're trying to do is stop that younger generation.

**Mr Kane:** May I interject here for just a second? You're suggesting that you don't want the younger children to smoke. I have kids of my own and I have grandchildren. I don't want them smoking. My kids don't smoke, although I did and I don't now, but that's beside the point.

The cigarette machines located where the federal law now has them are for the people who are supposed to be old enough to go into licensed establishments that are not available to teenagers. By limiting the cigarettes and having them available through corner stores or through whoever, young kids are still going to get them. It's going to be exactly the same as Prohibition, only they're going to be sold in schools by other kids that are old enough to buy them.

**Mr Owens:** So a restaurant like Denny's or another

family-type restaurant which does serve alcohol—

**Mr Kane:** The law says 80% of the beverage sales have to be alcoholic beverages.

**Mr Owens:** But there's still, in terms of the type of family restaurant or establishment that would be in my riding, access by minors.

**Mr Kane:** Not in a licensed establishment, there isn't. The current federal law says they're allowed to be located in alcoholic-licensed establishments only, bars, not allowed to be located in other places, and we're well aware that the law was supposed to come out on July 1.

**Mr Owens:** If I could have a quick question or clarification from the parliamentary assistant: My information seems to be at odds with the opinion of the presenter. Can you clarify the difference with respect to the federal law and who it covers?

**Mr O'Connor:** Our legislation goes much farther than the federal legislation does; it goes only to age 18. We felt a way of monitoring it better and enforcing it better would be to put it to the age that we have for the age of majority for drinking, which is 19. They have an age-of-majority card that they can present.

When the federal government was drafting its legislation it had some difficulty in taking a look at Ontario because licensed premises include family restaurants. Therein lies the problem that we have here in Ontario: licensed premises. You referred to that young lady I asked a question of. Young people can go into licensed establishments because licensed establishments can mean a family restaurant.

**Mr Owens:** Golden Griddle, Steve's Pancakes.

**Mr O'Connor:** So the difficulty we've got here then is that from the many presentations we had we never did find from anyone a suggestion that would say, how can that vending machine find out how old the person dropping the loonies in is? That's the key here.

**Mr Kane:** I agree with you on that one, but you're talking family restaurants. The federal law says that the sales have to be 80% alcoholic beverages. Those aren't family restaurants; those are bars, and the law in Ontario says 19, so if they're in a bar under 19 they're in illegally.

**Mrs Haslam:** No, only in—

**Mr O'Connor:** That's why I say we have a problem here in Ontario, because a licensed premise is still accessible to a young person.

**Mrs Haslam:** That's right, because at 17—

**Mr O'Connor:** I understand what you're saying, but the federal government's intention was well meaning and it doesn't apply to Ontario. We have a problem here in the province of Ontario that young people can still go into those establishments and have access to that vending machine that does not discriminate against how old that person might be. They may be going in to use the washroom, and quite often when they go past the washroom is when they pass that vending machine.

**Mr Kane:** Excuse me, but that's not true. The law in the province of Ontario under the Liquor Licence Act says that you have to be 19 to be in those premises. If



you're not 19 years of age, you're in there illegally. I used to operate the Dalhousie Yacht Club, and we kicked children out of the bar area continually because it's illegal for them to be there. That happens to be the law.

**Mr O'Connor:** I guess to clear this up, because this really does concern me if that's the case, I'd ask legal counsel to come forward so we can get some legal advice on this, because that's the problem we've got here.

**Mr Raj Asser:** It seems that anybody under 18 can go into licensed premises with their parents.

**Mr O'Connor:** That's not what we're talking about.

**Mr Asser:** For the purpose of having a meal.

**Mr O'Connor:** They just can't drink.

**The Chair:** We'll ask the legal counsel to comment.

**Mr Williams:** The gentleman is correct. I think there's roughly half a dozen licensed premises in this province that have restrictions on their licence placed on their establishment by the Liquor Licence Board because of instances where they've served minors. Other than that handful of premises, in all premises in Ontario a person of any age can go into those premises. They're not allowed to be served liquor, but they're allowed to be on those premises.

**Mr Kane:** The law has changed since I operated a bar.

**Mr O'Connor:** No.

**Mr Williams:** That's been since at least five years ago, because I wrote the statute.

**The Chair:** I think perhaps we've identified an issue here and we'll follow up on that, but clearly there's a difference of opinion.

**Mr McGuinty:** You raised a very good issue relating to I guess the federal approach. I have a copy of the regulations here, just so everybody can understand what we're talking about here. They define a beverage place. You can't have a vending machine now under the new law, which is 16 days old. You can't have it anywhere in Canada except in a beverage place, and a beverage place means a bar, tavern or other similar beverage room where alcoholic beverages are consumed, da-da, da-da, da-da, da-da, and you've got to have 80% of your total annual gross revenues from the sale of liquor, alcoholic beverages. So we're not talking here about a place like Denny's. It wouldn't qualify. It's got to be a bar, a tavern or something of that nature.

I don't think there are many children going into bars or taverns. There sure as heck shouldn't be.

**Mr Kane:** I hope not.

**Mr McGuinty:** Yes. What we're going to do here is that in an effort—and it's a noble intention no doubt—to reduce the incidence of smoking in children, we're going to ban vending machines in bars. I think there should be something else we could do to keep kids out of bars, to keep kids out of taverns—I think that's the real source of the problem here—and allow you to operate your vending machines in those bars and in those taverns, under the restrictive guidelines they have in place here, which describe that it's situated a distance of not more than five metres from the innermost part of the entrance and it's

got to be able to be directly monitored.

**Mr Perruzza:** You're saying vending machines are okay? Is that what you're saying?

**The Chair:** The question is directed to our witnesses.

**Mr Perruzza:** I wanted to know what he was saying.

**Mr McGuinty:** Just so Mr Perruzza understands, I think we could have vending machines in our bars and taverns, and I don't think our kids should be going into bars or taverns.

**Mr Perruzza:** You want to ban them from bars and taverns completely. That's what he's saying?

**Mr Carr:** I hate to break this to you, but I think, as you saw by the reaction from the members of the government side and the parliamentary assistant, that you're probably not going to get the changes. I believe that, as Mr McGuinty said, they're going to take one step to try to put you out of business and stop sales.

Yet over the last week or so or whatever it was, they probably did more to increase tobacco sales by reducing the taxes. Typical of socialists, they blame somebody else. It's never their fault. It's always the federal government's or somebody else's fault when things go wrong.

**Mr Perruzza:** Oh, you shouldn't just—

**The Chair:** Order, please. Mr Carr has the floor.

**Mr Carr:** Typical of these people, they're critical of the federal government. I wish they'd be as critical of their own government when they have the chance. You'd have more credibility, Mr Perruzza.

My question is, you've got a situation where you've now decreased taxes and yet they're going to put you out of business. I think reducing the taxes will encourage more people to smoke than putting you out of business will. Do you agree?

**Mr Kane:** Reducing taxes? It's going to encourage more kids to smoke, sure, because the 10-year-old with a quarter in his pocket, somebody's going to sell him a cigarette. That's what's going to happen. It's just the days of Prohibition, only it's tobacco now, that's all.

1450

**Mr Carr:** You may have mentioned this. In terms of economic impact, how large is your industry right now?

**Mr Kane:** There are approximately 6,000 machines in the province of Ontario. I know this doesn't agree with the figures of the federal government, and there's a real good reason it doesn't, because if you were reporting to Stats Canada and you sold a portion of your business off and you sent that in on the report, the next year you didn't get a report. Consequently, there are as many cigarette vending machine operators and private hotels etc that own their own machines that never reported to Stats Canada.

There are 6,000 machines at least, and it's going to cost a whole bunch of people their whole livelihood. It's that simple. You're going to put a lot of people out of business permanently, people who have put every cent they have into it, and giving them 90 days is criminal.

**Mr Asser:** I would like to bring your attention to a little article which says, "Mr Rae Seeks Payback for the Taxes He's Going to Lose," because the federal govern-

ment brought the taxes down. I'm going to lose 70% of my business and I'm seeking a paycheck. If the government is going to put me out of business, it had better buy my cigarette machines and decorate Queen's Park with them, because I have nothing else to fall back on.

**The Chair:** Thank you for your presentation.

KAY BOURNE

**Mrs Kay Bourne:** Good afternoon. I'm representing just my husband and myself. We have a small business called Bourne Vending. We've had it for a few years. We have vending machines. I hope you don't lynch me.

**Mr Carr:** It's legal.

**Mrs Bourne:** It's legal, that's the point. Most of our machines are in licensed premises where children do not go in. They're bars and taverns. We do have a couple in private clubs, like the Moose, where I think the average age is 45 and over. We have one in a factory.

Where we have a couple in places where there are restaurants, would there be any objection if we put them, say, in the kitchen area? The servers have to get the ID of the person where they are going to be served alcoholic beverages. They could ask them for their ID before they get cigarettes. The servers usually go and get the cigarettes out of the vending machines. Would there be any objection to that? I can't see why there should be. Most of our machines, as I say, are in legal places.

About something I saw on TV, these commercials that are supposed to stop children from smoking: My grandchildren think they're ridiculous. I have 13 grandchildren, and not one of them smokes, and I have seven of them who are over the age of 19 and four more coming up this year who will be 19.

We haven't got any kind of pension plan except our RSPs. What are we supposed to do with the machines? What are we supposed to have for our business income? Has anybody got any suggestions here?

I'd like you to ask me some questions about it. I'm going to be short and right to the point. You've heard everything else from the other people.

**Mr Sterling:** Simply put, our party has stated that we think you should be compensated for your cigarette machines. If you're going to be put out of business by the government—

**Mrs Bourne:** Well, we would be.

**Mr Sterling:** —then I think you should receive some compensation for your investment.

**Mrs Bourne:** I think maybe the provincial and the federal governments should get together on it if they're going to put us out of business. It shouldn't all be borne by one.

**Mr Perruzza:** How about all those people who work in a trade and all of a sudden find themselves out of work for years?

**The Chair:** Order, please. You will have your time for questioning.

**Mr Carr:** They get unemployment, Tony.

**The Chair:** Please. Mr Sterling has the floor.

**Mrs Bourne:** We don't get unemployment insurance.

*Interjection.*

**The Chair:** Order, please. Mr Perruzza, the way this committee functions is that each caucus has an opportunity to raise a question, and I would ask you not to interrupt. Mr Sterling has the floor, please.

**Mr Perruzza:** Yes, but he should stay away from crass political statements.

**Mr Carr:** You're saying that? Crass political you?

**The Chair:** Order, please.

**Mr Sterling:** I think there's a very, very important distinction between somebody who has invested their life savings in a business which has been heretofore legal, which you have done. I believe that if the government is going to say it's no longer legal to sell cigarettes from a vending machine, it should have some kind of compensation plan to buy you out at whatever the depreciated value of your machines might be.

I think that can be clearly distinguished from a person who loses their job, because a person who loses their job is not investing their life savings, hasn't put money up front, hasn't invested in a huge capital outlay on the premise that the laws were going to be all of a sudden radically changed for their lives.

**Mrs Bourne:** I understand.

**Mr Sterling:** I'm just saying that my party supports the position that you should be compensated, as we think the tobacco farmers should be and are compensated when they get out of growing tobacco.

**Mrs Bourne:** The only thing is, if you take the depreciated value of the machines, that's not going to do anything for our income, is it?

**Mr Sterling:** No, that's right, as we don't do anything for the income of people who no longer grow tobacco.

**Mrs Bourne:** I don't think that's very fair either. As you know, several of them have committed suicide because their farms have been lost.

**Mr Sterling:** Unfortunately, tobacco kills, and we have to deal with that in this government too.

**Mrs Bourne:** I wonder. There was a study done in British Columbia where they think a lot of the pollutants are coming from car exhausts. How about people who are in cars coming in, commuters, and going back every day? They're breathing in all these pollutants that must contain an awful lot of chemicals also. It's probably a combination of everything.

I don't agree with young people smoking. Don't get the idea I do. But we have a first generation of non-smokers in our own family, and at 70 I'm not going to go out and get another job.

**Mr Perruzza:** Very quickly, while I feel for what you're going through and I understand the difficulties that you'll experience, and there was a fellow just before you who maybe experienced the same kind of thing, I just want to pick up on a point that was made.

I represent a constituency where I've met with a good many people. I'll just relay the experience of one individual who invested about 22, 23 years of his life in a factory, learning how to make couches. I think he's 57 now. That man, as a result of federal legislation, free



trade, saw his plant move away. They relocated in Buffalo, where they're making couches now. That individual has been unemployed for, oh, two and a half years.

He probably isn't going to find any employment, and I don't think there's much in the way of a pension until he gets to the ripe old age of 65, which is, what, seven, eight years away? He's not going to have a job. He invested his whole life in learning how to make couches, invested in his company, invested in his company dearly through his efforts, through his skills and through his want to produce.

Nobody's coming along and compensating him for his investment. He invested in a company. The government came along, changed the law and said, "Sorry, folks, we're going to have free trade." His plant moved away. His job moved away. He's out there. Is Mr Sterling standing up and saying, "We should compensate him for the eight years, nine years until he gets a pension"? That's not what we're saying.

To ban young people from every place in Ontario: That's the other kind of absurdity we've heard today as well. I just think this has all gone too far. While I regret very much what may happen to you as a result of your losing your vending machines and while I regret what may happen to the other fellow who just appeared before you, cigarettes are a bad thing. They not only kill the person who smokes, but they kill the people who are within the general area of the people who smoke.

1500

**Mrs Bourne:** Always?

**Mr Perruzza:** By and large. I think studies and all of the experts who have come and made representation to this committee seem to suggest—

**Mrs Bourne:** Yes, they seem to suggest.

**Mr Perruzza:** That's the ugly side of cigarettes. When you look at some of the—

**The Chair:** Just a question there, because we do need to move on.

**Mr Perruzza:** My question really had to do with the whole issue of compensation. If we should buy all of the previous person's vending machines and decorate Queen's Park, as his question was, and if, as Mr Sterling is suggesting in making a recommendation here today, you should be compensated, should we then not compensate just about everyone else, especially that whole generation of older workers who are near the age of retirement who lost their jobs as a direct result of free trade and who will never regain employment?

**Mr Carr:** How are we going to solve that?

**The Chair:** Order, please.

**Mr Perruzza:** Should we be compensating them as well? I want to take their logic one step further.

**The Chair:** The witness has—

**Mr Perruzza:** If you want to play politics, let's play politics.

**Mr Carr:** How are we going to solve that?

**The Chair:** Order. Mr Carr, please. Mr Perruzza has the floor. He's asked a question of the witness. Mrs

Bourne, if you would be good enough to respond.

**Mrs Bourne:** This person that was going to lose their job, even though they had invested all those years, they probably have a company pension and they probably are going to get UIC.

**Mr Perruzza:** No.

**Mrs Bourne:** Why not? Severance pay?

**Mr Perruzza:** Their UIC lasts for a while and then they fall through the safety net.

**Mrs Bourne:** Will they not get a company pension or severance pay of any sort? I thought severance pay was mandatory.

**Mr Perruzza:** Not anything that has any real meaning. Many of these companies didn't have much to offer their people.

**The Chair:** We're going to move on.

**Mr McGuinty:** Mrs Bourne, thank you for your presentation and helping us to understand—

**Mrs Bourne:** Would you mind speaking a little louder, please? I'm a little deaf.

**Mr McGuinty:** Thank you very much for your presentation. You, like many other presenters who have come before you, help us to understand the implications of the bill on the front lines. This bill, like any other government bill, has got some good parts and some bad parts. By bad parts, I mean that some people are going to get hurt. The government feels that it is in the greater public good that this happen, that if a few people lose their jobs or lose some investments, there is a greater good at stake here and you become expendable. I think it's important for the government members to recognize that. That's what's happening.

You have been engaged in a legal practice. You have presumably been paying your taxes.

**Mrs Bourne:** Definitely.

**Mr McGuinty:** You may have raised a family on the earnings generated through this business, sent kids to school, put money in the church basket. I don't know. All of those things are legal and good and we have encouraged them in this society for a long, long time. Now we're changing the rules, and we're changing them abruptly. I think we have some obligation to minimize the impact, maybe by extending the time frame during which this business will be phased out. Maybe that's the minimum we could do.

**Mrs Bourne:** Are you still going to allow them to be sold in stores?

**Mr McGuinty:** Cigarettes? Yes.

**Mrs Bourne:** Then what's the difference with the vending machines if they're in a place where children can't get at them?

**Mr McGuinty:** I sit in opposition and I don't want to speak for the government on this, but I know why, and I think there's a good reason. The kids have access. We've got to minimize their access to vending machines.

**Mrs Bourne:** They can't get access if they're in a place where they can't get at them. When you go to a bar, the first thing they ask you for is your ID.

**Mr McGuinty:** I agree with you.

**Mrs Bourne:** If you go into a tavern, they ask you for your ID. If they're in a place where they serve food and they're where children can't get at them, nobody can get at them, only the servers, how are children going to get at them there? I've already asked some of the places I went to this morning to change the prices if they would put them in the kitchen where only the servers could get at them and ask for the ID, and they said yes, they would.

**Mr Owens:** Thank you for your presentation. In terms of the cigarette vending machine business, are you not currently seeing some level of diminishing returns?

**Mrs Bourne:** We did with the smugglers around, but now that it's starting to go down with the smuggling, our business has started to come up in the last week.

**Mr Owens:** The feds have passed legislation. Do you think that's going to impact on your business in a negative way?

**Mrs Bourne:** Which part do you mean?

**Mr Owens:** In terms of the location of vending machines.

**Mrs Bourne:** I don't think that will impact on it at all. I know they have to be 15 feet from the nearest entrance.

**Mr Owens:** Now, there are a lot of people on this committee and in the audience who are more knowledgeable about cigarette consumption in Canada these days, but my understanding is that consumption is going down. Is that not going to affect your business? If people simply cease to buy your product or buy the product from your machines, are you still expecting some level of compensation?

**Mrs Bourne:** Not if I could stay in business, no, because our business has not gone down that much before the smuggling started. I'm sure that when the smuggling has gone, we will sell just as many, because the people who go into bars and taverns are the ones who smoke.

**Mr Owens:** I just talked to a friend of mine at lunch break who bought a large king-size package of cigarettes for \$2.78 from a local store. The last time I saw a price on a cigarette machine, they were like \$6 or something.

**Mrs Bourne:** For a large package?

**Mr Owens:** No, for a small package.

**Mrs Bourne:** No, we used to charge \$5.50, but that included GST, PST and compensation to the people who had this machine in. Those people have to be compensated for every package.

**Mr Owens:** I guess my question is, there are some business issues that are already going to affect your business and you're not going to be compensated for them, particularly if people stop smoking.

**Mrs Bourne:** If everybody stops smoking, yes, but I don't think you're going to find that happen. I was brought up in a household that smoked. My husband was. My children were. Nobody has any problems: respiratory, heart or any other way.

**Mr Owens:** I hope you stay for the next presentation.

**Mrs Bourne:** Okay.

**The Chair:** Mrs Bourne, thank you very much for coming to the committee this afternoon. We appreciate it.

**Mrs Bourne:** I hope it does something to help.

**The Chair:** Members of the committee, we're going to take a short recess. We have to just get a few things moved around here prior to the next presentation.

*The committee recessed from 1507 to 1516.*

JAMES REPACE

**The Chair:** Dr Repace, welcome to the committee. I think we've got all of our technological elements in place. Perhaps I might, just for those who are watching, identify who Dr Repace is. I will just read this out. I think members of the committee have it.

"James L. Repace is a physicist and policy analyst. He has lengthy experience at the US federal level in indoor air pollution research and science policy analysis for the assessment and control of the risks of indoor and outdoor air pollutants. He has published 38 papers on ETS in scientific journals.

"His work is discussed in both the 1984 and 1986 Surgeon General's reports, the 1992 US Environmental Protection Agency report on passive smoking and the 1992 position paper on ETS by the American Heart Association.

"His work for the US Department of Transportation has also been utilized for the assessment of the risks of ETS to passengers and crew of commercial aircraft.

"He has testified by invitation as an expert witness on passive smoking before the US Senate and the US House of Representatives. He also served on the Surgeon General's National Advisory Committee on Smoking and Health from 1987 to 1992 and he has filled the role of scientific adviser on ETS to the World Health Organization since 1987.

"As recognition of his work, he is the recipient of the Dr Luther L. Terry award from the United States Public Health Professional Association in 1988 and the US Surgeon General's Medallion for his work on environmental tobacco smoke."

Dr Repace, we're delighted that you could be here today. I know you have some slides and so on to go with your presentation, so please go ahead. At the conclusion, I'm sure there will be a number of questions.

**Dr James Repace:** Thank you, Chairman Beer and ladies and gentlemen of the standing committee. It's a very great pleasure to be here to share with you some 18 years of experience that I've had on the issue of environmental tobacco smoke.

I would like, in my slide presentation, to briefly summarize what I think are the important points about environmental tobacco smoke and indoor air pollution and the control of environmental tobacco smoke by various social policies and engineering solutions, and then to answer any questions that you might have.

Amplifying my oral testimony will be the draft of a paper that I submitted to the St Louis University Public Law Forum that has many of the slides that I will show you. I will just summarize orally what the important



points are. Basically, public health professionals in the United States and abroad have come to a scientific consensus that environmental tobacco smoke is a class A or known human carcinogen. It has been judged to be a lung carcinogen. It very probably causes cancers other than lung cancers, although there are not enough studies at this point to be able to determine that definitively.

There are a very significant number of studies which suggest very strongly that environmental tobacco smoke is a cause of fatal heart disease, to a much greater magnitude than lung cancer. I'm going to focus mainly on the control of the lung cancer risks from environmental tobacco smoke.

This slide summarizes the agencies in the United States that have come to the conclusion that environmental tobacco smoke causes lung cancer and it constitutes every important federal public health agency that there is in the United States, so there really is a consensus at this point. The real issue is that tobacco smoke is a form of biomass combustion; it is like burning leaves; it is like burning wood; it is like burning coal or diesel fuel. It constitutes an incomplete form of combustion which releases many toxic and carcinogenic chemicals, somewhere between 4,000 and 5,000 chemicals, including 43 known carcinogens, many of them proven human carcinogens and the rest known animal carcinogens. So we are really filling our buildings full of highly carcinogenic vapours, which also are very toxic to other organ systems of the body.

If you look at the studies of active smoking and disease, you will find that there does not exist, to my knowledge, an organ system in the human body that remains undiseased in smokers; that is, they are prey to cancers of virtually every organ of the body at one time or another. So we're dealing with an enormously toxic substance.

The only people who seem to feel that tobacco smoke in the air is not a hazard to non-smokers are the tobacco people, and of course they have conducted a massive public relations campaign. I believe since the early 1980s, to try to convince the public that you would have to spend, for example, 100 hours in a smoky bar to inhale the nicotine equivalent of one cigarette, as if that were not a very significant risk. If we want public health information, we don't go to the tobacco industry; we go to the people who are paid to protect our public health.

So we can dispense with pseudoscience and I will talk briefly about the experiments which I performed in the Washington metropolitan area to take a look in the late 1970s and early 1980s as to exactly how much tobacco smoke was in the air, how it compared to air pollution from other sources and how it might be controlled. We used a device called a piezo balance—that's this little yellow box here—which is really a portable air pollution monitor. We carried it around to a variety of places where people were smoking or they were not smoking, indoors and outdoors, to sample the particles in the air, whether they were from tobacco smoke or anything else.

We sampled on the sidewalks of Washington, DC, obviously places where there was very little tobacco smoke, in vehicles on busy commuter highways in the

Washington area, in the homes of non-smokers, in churches during communion ceremonies—you can see there's a very high person-density here but no smoking—and then we went indoors to places where people were smoking. This was the Capital Center sports arena in the Washington metropolitan area during a hockey game and even though smoking was discouraged, people smoked anyway because there was no law against it. If you look carefully, you can see the smoke hanging in the lights here. We also sampled in the homes of smokers during dinner parties, in offices, in lodge halls, in restaurants—this is the Kennedy Center Roof Terrace cafeteria in Washington DC—in bars, in nightclubs—it's a little dark in this one—at weddings, in waiting rooms, in bowling alleys, in bingo games, in dinner theatres and in dives.

This is what we found. This is a plot of air pollution on the vertical axis versus the volume density of cigarettes on the horizontal axis. What you can see is these data points that have letters attached to them are all the areas where people were smoking indoors. These few data points down here, 33 data points, were the measurements we made with this air pollution monitor in the outdoor air and indoors where people were not smoking. The levels ranged from about 20 to 60 micrograms per cubic metre of particles, and indoors where people were smoking, you can see that every standard that the US Environmental Protection Agency had for air pollution in the outdoor air was violated, and even this one up here, which is called the significant harm level, in a bingo game we have 1,140 micrograms per cubic metre indoors and 40 micrograms per cubic metre outdoors.

So you can see that these are really conditions where tobacco smoke, as smoked under typical conditions of ventilation and building occupancy—this is what you get. You get a tremendous cloud of air pollution indoors which really cannot be controlled by ventilation and the reason it can't is because ventilation systems are designed for the removal of carbon dioxide from human metabolism and a replacement of fresh breathing air; they're not designed to remove a toxic and carcinogenic pollutant which is the result of biomass combustion.

If you take another look at this data, this again is a plot of the same data points, air pollution versus the density of cigarettes in the indoor air and now I have drawn in these dotted lines which show the air exchange rates in buildings. This is about half an air change an hour, which you get typically in very poorly ventilated spaces—nightclubs, office buildings—where they've shut the outside air dampers. This is the typical ventilation rate, seven air changes an hour, that you'll see in a well-ventilated restaurant that's operated according to code. The code in Canada is the same as it is in the United States. It's governed by the American Society of Heating, Refrigerating and Air-Conditioning Engineers, ASHRAE, which recommends building codes in North America.

You can see that, yes, the air pollution level does come down with increasing air exchange rate, but generally the places that have the higher air exchange rate are also the places that have the highest number of smokers. So it tends to counteract it, and you can see, even at seven air changes an hour in this nightclub, we're running between

300 and 400 micrograms per cubic metre and the US federal standard for inhalable particles is 50 micrograms per cubic metre. So you can see we're exceeding it by factors of five and six.

So ventilation, you can see, although it can lower the concentration of tobacco smoke indoors, cannot eliminate it. This is not a control measure for tobacco smoke. Although the tobacco industry has a very slick public relations campaign to try to convince the public that ventilation is the option for control of tobacco smoke, you can see that it is not. We'll return to this later. So you can see that we're dealing with a situation where, under typical conditions of building occupancy and ventilation, buildings are very polluted with biomass combustion products from tobacco. The question is really, what can one do about it?

The first thing that people tried was to put the smokers off in one corner of a room. Here's the State Department cafeteria in Washington, DC. This red bar is the smoking section and this shaded bar is the non-smoking section and this open bar here is outdoors. You can readily see that while the smoke level in the smoking section is higher than in the non-smoking section, the non-smoking section is not comparable to what it is outdoors, which it would be expected to be if there were nobody smoking. This is one of the things that we found: Indoor and outdoor levels were about the same when people were not smoking, but when people were smoking, they go up.

Here is a Denny's Restaurant, which is a large chain in the United States, and you can see again, even though the outdoor air levels are more polluted here because this is near a busy highway, it's still more polluted in the non-smoking section than it is out on the highway.

#### 1530

Here's the Goddard Space Flight Center cafeteria, which is operated by NASA in Greenbelt, Maryland, in the Washington area. They had a 3-to-1 ratio between smoking and non-smoking, and you can see that the levels in the non-smoking area are much, much higher than outdoors.

So physically separating smokers from non-smokers indoors really doesn't work, and it's very easy to understand why it doesn't work. We really are not reducing the environmental tobacco smoke loading of the room if we put the smokers off in one corner. A few minutes after a cigarette is smoked, the smoke will diffuse throughout the whole room. You might not be exposed to the very highest concentrations which come off the burning end of the cigarette, but you're going to be exposed to the average concentration that the tobacco smoke makes in the room. So this is not a control measure for tobacco smoke.

Suppose we look at what we call the dilution solution to pollution. We separate the smokers in another room in the same building but on the same ventilation system. That doesn't work, for a very fundamental reason. Tobacco smoke generates huge clouds of air pollution in a very confined area. Even a typical large building is a relatively confined area compared to the number of cigarettes which are smoked every year in the building.

What I've got here is a plot of the lung cancer risk from smoking versus the number of square feet per smoker, assuming a 10-foot height for the building. The idea is, how many square feet of building space would you have to have per smoker to get an acceptable cancer risk? In risk assessment, we talk about the concept of acceptable risk or de minimis risk. We say there is such a thing as a trivial risk, which is generally comparable to the risk of being struck by lightning while walking down the street in a thunderstorm. We don't regulate that risk. That is about a one-in-a-million risk and it's generally thought to be inconsequential.

If we could lower the risk from tobacco smoke indoors by dilution to an acceptable level, that might be considered okay as a control measure. Unfortunately, and you can't really read the bottom line here, to get to one in a million—this is a one-in-a-million lifetime risk, which risk assessment agencies like the Environmental Protection Agency, the Food and Drug Administration and OSHA might use as an acceptable risk—you'd have to go to about a million square feet per smoker. That's bigger than most buildings. You can't dilute tobacco smoke down without having buildings of huge volumes with one smoker in them. So this is not a control measure for tobacco smoke.

Suppose we try to do it by ventilation, which is the tobacco industry's favourite control measure. They don't ever say how much ventilation you need to get an acceptable risk. What they tell you is that ASHRAE has recommended, for a moderate amount of smoking, 20 cubic feet per minute per occupant, which in metric units is 10 litres per second of ventilation air per occupant. That is not a ventilation standard which is designed to control cancer risk. It is designed to limit the odour from tobacco smoke indoors, and if you read the standard, it says so. However, the industry implies that this is a health standard. So here again you've got lung cancer risk as a function of ventilation rate in cubic feet per minute per occupant. Here's what the ASHRAE standard recommends. It's a risk of about two or three per thousand, which is a very, very high risk for cancer risk assessors. We would like to be able to lower that down to a one-in-a-million risk, which is this bottom line, but if we did that we would need something in the order of about 50,000 cubic feet per minute per occupant, which obviously would suck everybody out of the room. So ventilation is not a control measure for tobacco smoke. Even if you wanted to pay for that much ventilation, it wouldn't be practical.

I think we can summarize what the likely possible control measures are for environmental tobacco smoke. Clearly if people smoke outside of buildings, that's acceptable. It is not going to increase the risk to non-smokers if the smoker is not in the building at all. The smoke will diffuse in the outdoor air and be a de minimis risk level for the world, but not for the non-smokers in the building.

The other control measure which many people advocate and which can work if it is done well is a separately ventilated area which is directly exhausted to outside the building and under negative pressure with respect to the



non-smoking areas of the building. Now, it can be done right. You can put an airlock in, you can ventilate the thing properly and you can make it work. But frankly, most people don't do it right and they don't make it work. Even when they try hard, they don't. Nevertheless, it is not an unreasonable control measure as a first step towards a total ban. This is what the US Environmental Protection Agency recommends as a control measure.

How does environmental tobacco smoke compare with other air pollutants? If you compare it to radon gas for non-smokers, you can see that we have about 5,000 deaths a year, plus or minus 2,500, in the United States from lung cancer alone from passive smoking, and it's probably about nine times that many from heart disease, so it's a very, very large number. If you look at radon alone, it's about 3,000 to 4,000 and if you look at all of the outdoor air pollutants regulated by the United States federal government—asbestos, vinyl chloride, airborne radionuclides, outdoor nuclides, coke oven emissions from steel plants, benzene emissions from petrochemical plants and arsenic from copper smelters—you will find that the total of those is less than about 90 deaths a year. So you can compare that with 5,000 deaths a year and you can realize that we're dealing with numbers which are 50 or 60 times higher for tobacco smoke than all of the regulated outdoor hazardous air pollutants combined. This is not a trivial environmental risk, and the numbers that we look at here for the United States are about 10% in Canada, based on a prorated population basis.

So we are dealing with a chemical that is really very hazardous. It's a class A, known human carcinogen. There are only about a dozen of those that we know are known human carcinogens, and this is one of them. Thank you.

**Mr Owens:** Thank you for an excellent presentation. Unfortunately, the person I really wanted to hear this presentation left before you spoke.

In terms of even the issue of smoking in the great outdoors, if you're sitting in an outdoor patio, is there a potential for a synergistic effect to take place between the properties in the cigarettes and the hydrocarbon emissions from passing vehicles?

**Dr Repace:** Yes, there is, although outdoors obviously there is no enclosed volume for the tobacco smoke to accumulate in. But that doesn't mean it can't impact on you. For example, outdoor air pollution is regulated from factory chimneys on the basis of the fact that the wind will blow it downwind on to you and it will cause some harm. Therefore, we try to limit the amount of factory emissions from chimneys.

Similarly, if someone is sitting outdoors, even though the smoke can't really accumulate, if that little plume from that cigarette impacts on you, it will certainly be able to cause harm. It is nowhere near as bad as it is indoors, and probably the main problem is that it's quite offensive to non-smokers; it's very irritating. For example, a lot of people have the experience, if they go to a beach and go downwind of a smoker, even at 100 yards away it can be very obnoxious because you don't expect to have that experience; you're expecting clean air off the sea and instead you're getting tobacco smoke up

your nose. It's not going to give you cancer, but it's going to really annoy you.

**Mr Owens:** In terms of opposition that I've heard to the legislation, they talk about alcohol being more dangerous to people. Do you have an understanding of what the mortality rate is for alcohol vis-à-vis cigarettes?

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**Dr Repace:** I think that alcohol is probably considered one of the leading preventable causes of death in the world, and that's certainly true, but active smoking I think is greater than alcohol by a long shot. I don't know what the exact numbers are, but I think it goes this way: Active smoking is the worst preventable cause of death, alcohol is second, and passive smoking is third. We have about 50,000 deaths a year in the United States from passive smoking, so that would place it third in the hierarchy of preventable causes of death, and after alcohol. Alcohol is worse than passive smoking but not as bad as active smoking.

**Mr Owens:** So if we were really smart about this issue, we would make cigarettes illegal and not worry about vending machines and pharmacists. Clearly, from the presentation that you just finished giving, if anyone needs any further evidence that we're dealing with a known hazard, then I don't know what more evidence we need.

**Dr Repace:** That's certainly true. I think a lot of people would agree that banning cigarettes outright may not be a practical thing to do. We tried to ban alcohol outright in the United States and it didn't work. People who want to harm themselves always find a way to do it, and if you tried to ban every illegal substance, pretty soon we wouldn't have anything to work with any more. So banning cigarettes may not be a practical thing. It might be, from the public health point of view, a very desirable thing to do.

But certainly we can restrict the places where people are allowed to smoke, just as we restrict the places where people are allowed to drink. Drinking is perfectly legal in most countries of the world, but in almost every country of the world, it is illegal to drink and get behind the wheel of a car.

**Mr Owens:** So you don't buy the civil rights: "This is my constitutional right to be able to take up a cigarette."

**Dr Repace:** Not in a building. I would defend the right of the smoker to smoke outdoors or in any place where it's not going to harm anyone else, but I think it's a well-established principle of our civilization that society acts to control involuntary risks. We don't like to have risks imposed upon us against our will, and we ask that our society protect us from that. We are protected from drunk driving, and we should be protected from people smoking in buildings unless it's their own building, their own premises, and no one is being exposed involuntarily.

**Mr Sterling:** Thank you very much for your presentation. I think this is the second time I've had the pleasure of listening to your presentation. When was the last time you were in front of a committee here? The workplace legislation?

**Dr Repace:** It was a number of years ago. Yes, it was the smoking-in-the-workplace bill.

**Mr Sterling:** I appreciate having expert witnesses in to talk about these matters. Have you had an opportunity to look at Bill 119?

**Dr Repace:** Yes, I have.

**Mr Sterling:** I guess the most attractive part of this bill for me—unfortunately, I don't think Bill 119 does nearly enough or really addresses the key and significant issues. One of them is the weak workplace smoking legislation which we have in this province and which I had really hoped this government would address but it hasn't addressed. I'll tell you, if we are lucky enough to be the next government, I will address that at that time.

The part I like about this legislation is the controls to smoking in some public places, because in this province we don't have uniform legislation. We have stricter controls than some of the larger municipalities, but some of the people in the smaller municipalities have no relief from secondhand smoke when they walk into a public place in their municipality. A lot of that relates to the ability of those municipalities to do something as sophisticated as this, because we have some very, very small administrations. Some townships are 200, 300 people.

**Dr Repace:** Right.

**Mr Sterling:** Section 9 of the act outlines a number of areas. There are eight different kinds of areas. You've done a lot of research in various different kinds of enclosed spaces. What would be your recommendations in expanding that list? There are eight specific ones and then the Lieutenant Governor in Council can by regulation put other ones in.

**Dr Repace:** Right. I would approach it, I think, a different way. I wouldn't expand the list to try to include every conceivable location that people can think of, because you can never think of them all. I would simply ban smoking in all public places and all workplaces and then I would allow exceptions to be made if the owner of the premises can demonstrate that he or she is adequately protecting the non-smokers in the building. In other words, they could be allowed, under certain circumstances, to establish separately ventilated areas under negative pressure according to the building code, which specifies how these things are to be built and installed, and if they can demonstrate to the satisfaction of the authorities that they don't leak tobacco smoke. I didn't touch on this, but you can now measure the nicotine in the air. If it's above a certain level, it's going to be an unacceptable risk, so you could actually enforce this kind of a standard. Otherwise, you're left with producing a laundry list of places where people can't smoke. It's better to establish non-smoking as the norm and smoking as the exception if you can demonstrate that it can be done safely.

**Mr Sterling:** The other area that I'd like to ask you about is I think you're quite familiar with our Smoking in the Workplace Act. How do you think that should be strengthened in terms of legislation that we presently have in place in Ontario?

**Dr Repace:** I think the workplace act says that you

can have smoking in up to 25% of the floor area of an establishment in a workplace. As far as I can tell, it needn't even be a contiguous 25%, so you could have little areas all over the place. A moment's reflection will tell you that does not reduce the environmental tobacco smoke loading of the building at all. It's going to reduce the concentration of the smoke which goes from my cigarette past your nose, because it generally may be further away, but the average concentration of the smoke in the building is not reduced. There is no measure. You haven't increased ventilation, you haven't increased the volume of the building, you haven't reduced the amount of smoking, so the concentration in the building really doesn't change, and so the cancer risk doesn't change; the heart disease risk doesn't change. All you've done is maybe reduced the irritation a little bit.

It's a cosmetic approach. It's certainly a step in the right direction, but I would not call it a control measure for class A carcinogens, and that's what we are now dealing with. I'm not sure that when that act went into place it was widely understood that it was a class A carcinogen, but I think now there is no public health authority in the world that doesn't accept that. Now is perhaps the time to revisit it and to strengthen the Smoking in the Workplace Act. Whether this particular bill is a vehicle for doing that, I can't say, but it appears that you might be able to do that.

**Mrs O'Neill:** I think this has been very powerful testimony, as we had some pretty powerful testimony from our last presenter this morning. I'm just wondering if this committee is going to react to this by having our Chair write to the Minister of Labour telling of the experiences we've had on this committee and asking that the bill be reopened and strengthened. I think we've had enough evidence. Many, many times—likely up to 20 times—this issue has been mentioned in the course of our hearings. I think the least we can do is show that we as a committee want this bill reopened and studied by both Labour and Health.

**Mr Martin:** Just in response to that directive that just came from the Liberals, we've had people come in here and talk to us about the concerns they had. This becomes very much an ethical question. We know the information. Everybody knows that tobacco smoke's bad for you. Environmental tobacco smoke's even worse in some instances, depending on where you are. We've had groups come in looking for exemptions because their area has a particular nuance to it that makes it difficult and all this kind of thing. Whenever they come, the opposition is very supportive of that, and I have to say my heart goes out sometimes too, because you're tugged and you're pulled in different directions here.

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This morning we had a group of students come who said that they wanted their area exempted in some instances and for the most part the exemption would apply to closed-in areas for students, who claim they are more adult now than youth, at colleges and universities. Mr McGuinty was outside talking to the leaders of that group about how we might do something by way of exemption in this act, and I have to say that I did too.



We can't suck and blow at the same time, and the question here is, and it's for all of us, where do we land? Do we really want the Ministry of Labour to come forward with some really restrictive regulations that will disturb and perturb a lot of our constituents? Certainly mine in Algoma Steel—there are an awful pile of people there who still love to smoke and I'll tell you it will cause me some anxiety if it's known that I'm bringing that forward. It's a dilemma.

**Mrs Haslam:** Is this legislation a good first step? Are we on the right track with this legislation?

**Dr Repace:** To the extent that you want to do something, I think it is a good first step, but you have to ask yourselves whether it's an adequate measure. I would have to say that it could be greatly improved by really taking a much more positive attitude towards establishing non-smoking as the norm.

I can tell you, in the United States non-smoking is rapidly becoming the norm. In 60% of our workplaces now we basically have non-smokers either protected by bans or separately ventilated areas. This is mostly voluntary. There are only about 13 states that actually regulate smoking in the workplace. In the city of Los Angeles, which is, as you know, a very, very large city with a large number of restaurants, there is no smoking in any restaurant any more. In most of the small towns and cities in California, there is no smoking indoors any more in workplaces and in public buildings. The rest of the United States is rapidly moving in that direction. I think I can predict that the United States Occupational Safety and Health Administration is moving in that direction. They have announced a request for information and it is believed that they are drafting a rule now to control smoking in the workplace.

I can say that non-smoking really has to be established as the norm. Smoking is something that we all took for granted. Smoking permeated all of our buildings and it came to be regarded as natural, but it really is not. It really is biomass combustion in a confined space, and our buildings are not really designed for it. If people want to practise nicotine addiction, which is really what it is, that's fine and that's their right, but they shouldn't do it inside buildings where other people can be exposed.

**Mr McGuinty:** I have a couple of questions. First, if I can't smell cigarette smoke, does that mean I'm safe?

**Dr Repace:** No. It may mean that your nose has adapted to the odour of tobacco smoke. For example, in a large building many people believe that because there's, let's say, no smoking on their floor, but there might be smoking on another floor, even on a different ventilation system, they're unexposed. But research has shown, in terms of measuring nicotine concentrations, that this is not true. For example, in a high-rise building where there was smoking on the 32nd floor nicotine was measured on the 30th floor, which was on a different ventilation system.

That might seem strange, but give a moment's pause to how our buildings are constructed. They're pierced often by large elevator shafts which are really pistons moving up and down and creating overpressures and partial vacuums every time they move, so they're always

sucking air from one part of the building and pushing it into another. We have stairwells where smoke can drift up. We have wind blowing on one side of the structure and creating a partial vacuum on the other. You've got chimney effects.

Over the course of the day, what happens on one part of even a very large building is going to be communicated to other parts of that building. We're going to breathe on the 32nd floor what might be generated on the first floor over the course of a day. You really can't get away from smoking in buildings. I can't overemphasize how much smoke is made by a single cigarette. It's just an enormous amount of air pollution. Our buildings' ventilation systems are not designed to cope with it. If we wanted to make them cope with it, we couldn't afford it.

**Mr McGuinty:** Tell me a bit more about—because nobody's spoken to us about this before—the toxicity of the tobacco, I guess, the byproducts as a result of combustion. Is that a function of additives or is just the natural product itself toxic?

**Dr Repace:** No, it's the natural product itself. If you burn something completely, an organic chemical, you're going to burn it into carbon dioxide and water vapour. If you burn it hot enough, you're going to make a little bit of nitrogen oxides. If you burn it incompletely, you're going to break the organic molecules down into smaller ones, and often they're very nasty things. They're toxic, they're carcinogenic and they can otherwise injure the body. That's really basically the problem, and that's true whether you're talking about tobacco or grass or leaves or coal or oil or gasoline. You're burning something incompletely and it's going to cause the products of incomplete combustion to form, and they're always nasty chemicals.

**Mr McGuinty:** You've had an opportunity, I gather, to appear before a number of committees, tribunals. You've met with movers and shakers in the anti-smoking movement throughout North America. Are there any other jurisdictions that have banned smoking in the workplace, for instance, outright, state-wise?

**Dr Repace:** The entire state?

**Mr McGuinty:** Yes.

**Dr Repace:** No, I don't believe so. I don't think there is a state-wide ban on smoking in all workplaces. There are certainly localities which do that, but I don't think at this point we have a state-wide ban.

**Mr McGuinty:** What are the classical reasons put up for not doing these kinds of things?

**Dr Repace:** I think the reasons that people put forward are generally economic or they're ones of inconvenience. Restaurateurs, for example, are fearful that if they ban smoking then people will go elsewhere to smoke, and that's been demonstrated to be not true. There's been solid research in the state of California that shows it really doesn't matter. People go to restaurants to eat, not to smoke. Generally, the arguments that have been put forward are very weak arguments, because they don't deal with the fundamental crux of the issue, that we have a class A carcinogen we're dealing with that needs to be controlled. That really takes primacy over every

other argument. For example, if this hearing were about some substance called environmental tobacco smoke that the water treatment system wanted to put in the drinking water because they felt it would enhance its flavour, would there be any doubt? Would you allow environmental tobacco smoke to be baked into bread in the city of Toronto? I don't think so. Would you allow it to be put into Coca-Cola?

That really is the issue. You know, we have standards for the delivery of quality of outdoor air, of food and of drinking water. Unfortunately, we haven't as a society come to grips with standards of quality in the delivery of indoor air. That's really what this is all about. You don't put these kinds of standards into place without treading on economic interests, without treading on people's sensibilities, but really it's a public health issue.

It's like malaria control. It really needs to be done and this is the time to do it. We have enough information to do it. We have the political and social means to do it. There are certainly some areas of the population that are not prepared to go along with it. I think that is a matter of public education. Certainly one of the things that government can do is to bring the population along by educating it. There are established means for doing that, and this is certainly one of them.

**Mr McGuinty:** Just one final question, please: One of the problems we face here, as I'm sure you'll recognize, is that it's pretty darned cold up here in the winter. Are there any cities in the northern states which have banned smoking in the workplace, for instance?

**Dr Repace:** I really don't know. I am not completely up on who has banned smoking where. My main emphasis is on how you control tobacco smoke or how you can't control tobacco smoke and what it does to indoor air. On the political side, in the state of Minnesota they certainly have lots of restrictions. I would look there to see whether they have banned smoking in the workplace, but I'm not sure.

It was a specific issue in a hearing of the veterans administration hospital system when it went smoke-free. I happened to be an expert witness in the case of the veterans administration hospital system versus one of its labour unions. The issue was that all the divisions of the Department of Health and Human Services and allied systems that went smoke-free often did so without consulting all their unions. One of them raised this as a labour issue and the VA argued that it really was not subject to bargaining because it was a health issue.

One of the nurses for a psychiatric veterans' hospital came in and said: "Look, I'm 56 years old. I smoke. I've been smoking all my life. I would like to be able to continue smoking. I know it's going to kill me. I can't step outside to smoke because I work in a high-security facility. I can't leave my patients alone. It's going to be a terrible hardship." They went ahead and banned it anyway and all of the imagined problems that were going to come about because of this disappeared. What happens is that people quit smoking if they can't smoke, if they go outside and it's too cold. If they quit smoking, what happens? They live longer, and that's not such a bad punishment.

**The Chair:** Dr Repace, on behalf of the members of the committee, I want to thank you for being with us this afternoon, for your slides and for sharing your experience with us. We appreciate it.

**Dr Repace:** Thank you. It's been a great pleasure to be here.

**Mrs O'Neill:** I have just made a request. I thought there would be unanimous consent for that. I didn't hear it.

Secondly, I did ask for a definition of "pharmacy" and I did ask for a list of the programs that were available to those tobacco producers who wanted to leave the industry. I think they're fundamental. Today's the last day we're going to meet before we go into clause-by-clause. Are those things going to be forthcoming and do we have permission for you to write a letter to the Minister of Health and Minister of Labour?

**The Chair:** On the latter point, the Chair of course is in the hands of the members of the committee.

**Mrs O'Neill:** I'll make a motion that we send a letter and I would like it to be taken to a vote. I would ask for a recorded vote.

**The Chair:** Could you state your motion?

**Mr Owens:** I don't think anybody's disagreeing with it. I don't see the parliamentary assistant having serious—so why don't we just say okay and let's move on.

**The Chair:** Just so I know what it is, then, that I'm doing, this would be a letter to the—

**Mrs O'Neill:** I would like you to state—and maybe the clerk would be able to give the exact number or an estimate; mine is around 20 presenters. Some more explicitly than others have asked for this workplace act to be updated, to be opened again and that the Minister of Labour and the Minister of Health be so informed.

**The Chair:** Is it agreeable to the committee if, together with the clerk, I draft a letter and then show it to the two critics and the parliamentary assistant? If it is seen to be fine with them, then I would sign it and send it on behalf of the committee. Is that agreeable to everyone?

**Mr Owens:** Agreed.

**Mrs O'Neill:** Agreed.

**The Chair:** Fine. Then with respect to the letter to the Minister of Labour, I will go forward with that.

Now there were two other points of information.

**Mr O'Connor:** On the other information, would you like to receive that information before we get to clause-by-clause? I know you'd like it today; I don't have it with me today. But would you like to receive that before clause-by-clause or the very first day?

**Mrs O'Neill:** Very much so. That's why I made the request about a week ago, because I thought it might be possible to have it for today. I certainly think we need to have it before we begin clause-by-clause, yes.

**Mr O'Connor:** I appreciate that.

**The Chair:** Okay, so that will be done. We will reconvene on Monday, March 7.

The committee adjourned at 1605.









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 Haslam, Karen (Perth ND) for Mr Hope  
 Perruzza, Anthony (Downsview ND) for Ms Carter  
 Sterling, Norman W. (Carleton PC) for Mr Jim Wilson

### **Also taking part / Autres participants et participantes:**

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**Clerk / Greffier:** Arnott, Doug

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## Assemblée législative de l'Ontario

Troisième session, 35<sup>e</sup> législature

# Official Report of Debates (Hansard)

Monday 7 March 1994

# Journal des débats (Hansard)

Lundi 7 mars 1994

**Standing committee on  
social development**

**Comité permanent des  
affaires sociales**

Tobacco Control Act, 1993

Loi de 1993 sur la réglementation  
de l'usage du tabac

Chair: Charles Beer  
Clerk: Doug Arnott

Président : Charles Beer  
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## LEGISLATIVE ASSEMBLY OF ONTARIO

## ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON  
SOCIAL DEVELOPMENTCOMITÉ PERMANENT DES  
AFFAIRES SOCIALES

Monday 7 March 1994

Lundi 7 mars 1994

The committee met at 1320 in room 151.

TOBACCO CONTROL ACT, 1993

LOI DE 1993 SUR LA RÉGLEMENTATION  
DE L'USAGE DU TABAC

Consideration of Bill 119, An Act to prevent the Provision of Tobacco to Young Persons and to Regulate its Sale and Use by Others / Projet de loi 119, Loi visant à empêcher la fourniture de tabac aux jeunes et à en réglementer la vente et l'usage par les autres.

**The Vice-Chair (Mr Ron Eddy):** The work of the committee is to commence clause-by-clause consideration of Bill 119.

Are there any amendments, questions or comments regarding section 1? If not, shall section 1 carry?

**Mr Jim Wilson (Simcoe West):** Just one moment, Mr Chair. We'd like to actually take our seats.

**Mr Norman W. Sterling (Carleton):** I have a copy of the government's amendments. I don't have a copy of any Liberal amendments.

**Mrs Elinor Caplan (Orlino):** They're in the package.

**Mr Larry O'Connor (Durham-York):** They're sitting in front of you.

**Mr Sterling:** Okay. I want to give you a copy of our amendments at this stage of the game.

**The Vice-Chair:** Do we have copies for all members?

**Mr O'Connor:** Oh, there are Conservative amendments.

**The Vice-Chair:** What's the first amendment? Section 4. What is your wish, committee members? The PC amendments to the bill have been submitted but we don't have copies. The first amendment I believe is section 4. Do you wish to proceed to section 4?

**Mrs Caplan:** Yes. We could proceed until we get there, and by then we should have the amendments.

**The Vice-Chair:** Agreed? Thank you.

Section 1: Are there any amendments, questions or comments regarding section 1 at this time? If not, shall section 1 carry? Carried.

Section 2: Any questions? Shall section 2 carry? Carried.

Section 3: There is a government motion regarding section 3.

**Mr O'Connor:** I move that section 3 of the bill be struck out and that the following be substituted:

"Selling or supplying to persons under nineteen

"3(1) No person shall sell or supply tobacco to a person who is less than nineteen years old.

"Selling or supplying to persons apparently under nineteen

"(2) No person shall sell or supply tobacco to a person who appears to be less than nineteen years old, regardless of the person's actual age.

"Defence

"(3) It is a defence to a charge under subsection (1) or (2) that the defendant believed the person receiving the tobacco to be at least nineteen years old because the person produced a prescribed form of identification showing his or her age and there was no apparent reason to doubt the authenticity of the document or that it was issued to the person producing it.

"Same

"(4) It is a defence to a charge under subsection (2) that the person selling or supplying the tobacco had personal knowledge that the person receiving the tobacco was at least nineteen years old.

"Apparent age

"(5) In a prosecution under subsection (1) or (2), the court may determine, from the person's appearance and from other relevant circumstances, whether a person who received tobacco appears to be less than nineteen years old.

"Improper documentation

"(6) No person shall present as evidence of his or her age identification that was not lawfully issued to him or her."

**Mr Dalton McGuinty (Ottawa South):** Regarding subsection 3(6), is there a penalty provision accompanying this as well? I gather it's saying that if you're under 19 and you—

**Mr O'Connor:** At this point, no, there isn't.

**Mr McGuinty:** There is no penalty provision for subsection 3(6)?

**Mr O'Connor:** For the person producing the identification or the person—

**Mr McGuinty:** The person producing it. Yes, so if you're fraudulent; you're putting forward identification which isn't true: I'm 16 and I show you something that says I'm 20. This covers that, I assume, right?

**Ms Brenda Mitchell:** Yes.

**Mr McGuinty:** That's what we're talking about here?

**Ms Mitchell:** Yes.

**Mr McGuinty:** Is there a penalty for doing that?

**Ms Mitchell:** I'll ask legal counsel.



**Mr O'Connor:** If you refer to our table—there's an amendment to the table—you'll note that this section is referred to in the table in the first large box that has a whole pile of sections that are referred to. That's where that kicks in.

**Ms Mitchell:** It would be under column one for the provision contravened. It now refers to subsection 3(6), and the penalties would be similar to other penalties in that section for offences under that section.

**Mrs Yvonne O'Neill (Ottawa-Rideau):** Excuse me, what are you talking about—table?

**Mr O'Connor:** That's in the bill currently, page 8 of our bill, but there is actually an amendment that will change that.

**Mrs O'Neill:** "Provisions contravened"? Is that it—table, number of earlier convictions?

**Mr O'Connor:** That's the one, yes. You'll note the section that Mr McGuinty has asked the question about, subsection 3(6), shows up in that very first box.

**Mrs O'Neill:** I see. So those are the fines.

**Mr O'Connor:** Yes.

**Mr McGuinty:** The purpose of this, just so I'm clear again, is to penalize young persons who are attempting to misrepresent their age through false documentation. Is that right?

**Ms Mitchell:** Yes.

**Mr McGuinty:** Is that what we're after here?

**Mr O'Connor:** No.

**Mr Jim Wilson:** Well, why?

**The Vice-Chair:** Is there a response to that question?

**Mr Jim Wilson:** Perhaps it could be better put to give leeway to legislative counsel or the parliamentary assistant to simply explain subsection 3(6).

**The Vice-Chair:** Thank you for your suggestion. Legal counsel will respond.

**Mr Frank Williams:** I'm sorry, do you want to start back with your question again, because I missed part of it back in the corner. I assume you want to know if there was an offence for somebody—

**Mr McGuinty:** First of all, is there an offence created? It says here you can't do this; you shall not do it. Is there a sanction that's involved?

**Mr Williams:** Subsection 14(1) creates the offence and the corresponding section in the table, that's correct.

**Mr McGuinty:** And there are fines associated with that, fine.

**Mr Williams:** To the extent that, under the Provincial Offences Act, a young person could be fined. It would have to be somebody 13 years of age and older, which is consistent with what's in the Liquor Licence Act now on identification.

**Mr McGuinty:** If that's the intention, I just want to say I wholeheartedly endorse it.

**Mr Jim Wilson:** I appreciate the amendment, but I would like a bit of a layman's explanation as to why this section has now taken this form, and in particular the dropping of clauses 3(3)(a) and (b) in the original Bill

119 and their replacement by subsection 3(5). Could we just have legislative counsel explain the new approach, or perhaps the parliamentary assistant?

**Mr O'Connor:** The rationale for the changes here is it will make it more consistent with the Liquor Licence Act. Of course, some of this was also supported by people through the hearings; for example, the Canadian Cancer Society and Ontario Campaign for Action on Tobacco, the London home and school association, so parts of this were supported by people who came before the committee. In fact, it makes it consistent with what we heard from people as well as makes it fall together with the Liquor Licence Act better.

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**Mr Jim Wilson:** So this very much mirrors it. Is it identical to the identification provisions in the Liquor Licence Act?

**Mr O'Connor:** Pretty much so.

**Ms O'Neill:** The form of identification they're suggesting is going to be similar to the ID regarding 19 for drinking. Some people have suggested photo ID. Is this going to be a special ID card then, or what kind of ID is going to be accepted as accurate documentation?

**Mr O'Connor:** Right now there's the age-of-majority card, which I think would be the most appropriate. That's why we've moved it to the age of 19; it makes it that much easier. Students will have that piece of identification there, as well as a driver's licence.

**Mrs O'Neill:** Will the notes to the bill contain then what "prescribed form of identification" means? If you have something already in mind—but certainly "prescribed form of identification" doesn't indicate whether you're going to have a new form of identification in regulations or whether you're going to accept the age-of-majority card, which is generally known—or a birth certificate for that matter.

**Mr O'Connor:** For further clarification, I'd ask Brenda Mitchell to help us here.

**Ms Mitchell:** The intent is that the prescribed forms of identification would be specified under regulation and would be consistent with the Liquor Licence Act. At this time I believe there are five forms of identification allowed under that act; all of those are photo identification. But it could be that the specific mechanisms that there are in Ontario for photo ID may change over time and we'd like to be able to change it to be consistent with that. One of the forms is the age-of-majority card. There are also forms such as passports, which also require photo ID.

**The Vice-Chair:** Any further questions or comments? If not, all those in favour of the government amendment to section 3, please indicate. Opposed? Carried.

Shall section 3, as amended, carry? Carried.

Section 4, a government motion.

**Mr O'Connor:** I move that paragraphs 3, 8, 9 and 10 of subsection 4(2) of the bill be struck out and the following substituted:

"3. A psychiatric facility as defined in the Mental Health Act, except, in the case of a facility that is

designated under the Mental Hospitals Act, a part of the facility where the sale of tobacco is authorized by the regulations.

"8. A pharmacy as defined in the Drug and Pharmacies Regulation Act.

"9. An establishment where goods or services are sold or offered for sale to the public, if,

"i. a pharmacy as defined in the Drug and Pharmacies Regulation Act is located within the establishment, or

"ii. customers of such a pharmacy can pass into the establishment directly or by the use of a corridor or area used exclusively to connect the pharmacy with the establishment.

"10. A place that belongs to a prescribed class."

**Mr Jim Wilson:** Just to go through and comment on the amendment, I think with respect to paragraph 3, a psychiatric facility, I can certainly have some agreement there. I assume the intent is to designate a smoking area for the—sorry, not a smoking area, a place where cigarettes can be sold in those facilities as defined in the Mental Health Act.

**Mr O'Connor:** That's correct. It's under the Mental Hospitals Act and it's consistent with what we heard from people making presentations.

**Mr Jim Wilson:** I appreciate that with paragraph 8 you're trying to clear up the definition of "pharmacy" which was requested by a number of presenters. I remain opposed to the ban with respect to the sale of tobacco products in pharmacies. I think Mr Sterling, my colleague, disagrees with me on that, and you'll see some interesting voting patterns this afternoon, no doubt.

Why the change with paragraph 9? Are you just adding the definition of "pharmacy" as under the act?

**Mr O'Connor:** Yes.

**Mr Jim Wilson:** So there's no other effect.

**Mr O'Connor:** No, it's to clarify it, and it's consistent with what we heard through the hearings.

**Ms O'Neill:** I guess my question is similar to Mr Wilson's: "is located within the establishment," and again, that still begs a definition in my mind in these very large retail establishments, "within" then means within a two- or three-storey building.

**Mr O'Connor:** That's correct.

**Ms O'Neill:** Even though there are escalators and all of these other things that could be determined to be part of 9(ii), this is a very, very broad definition of the word "pharmacy"—very broad.

**Mrs Caplan:** That's what I was going to ask. I very much support the prohibition on the sale of cigarettes and tobacco products by health professionals, and most specifically by pharmacists. I'm wondering whether or not this new definition would capture all pharmacies or pharmacies within larger stores where drugs were dispensed by a health professional, namely a pharmacist.

**Mr O'Connor:** To help clarify for yourself and for others, the intention is so, that the pharmacy, whether the pharmacy be within that area, that the area selling tobacco products, if the store wishes to remain a phar-

macy, then that tobacco would either have to be removed or they would decide the other and not be a pharmacy any longer. I think it's pretty clear that the definition is to make sure there is no difference between the pharmacy, whether it be part of a large chain that's included in a department of a department store, a pharmacy is going to be a pharmacy.

**Mrs Caplan:** The amendment that you've brought forward today would cover any drug dispensary no matter where it was located? That's the intent.

**Mr O'Connor:** Yes.

**Mrs Caplan:** That's fine. What it will do is relegate the sale of tobacco and tobacco products to tobacco stores, smoke shops, variety stores, that sort of thing.

**Mr O'Connor:** Yes.

**Mr Sterling:** Can I just ask a question on 3, your amendment to it? Why do you need to regulate this? Why don't we just take them right out? What's the purpose of putting it this way?

**Mr O'Connor:** As we went through the hearing process, we had—

**Mr Sterling:** I know the reason that we want to cut them out, but why don't we just take 3 right out of the act and say a psychiatric facility, as defined in the Mental Health Act, is not covered? Why do we have to regulate this? We're going to take it out and then we're going to regulate it and say, "You can sell cigarettes in that corner of the hospital." Don't we trust these people to do whatever's right?

**Mr O'Connor:** The key here, as we heard through the hearings, was that it's the patients who are so addicted that they have the opportunity to purchase, not for the staff, so it's not a regular retail outlet. It would be only geared for them. At the same time, there is a need for regulation of smoking in a psychiatric facility as defined under the Mental Hospitals Act.

**Mr Sterling:** No, but this has to do with the sale of cigarettes; it doesn't have anything to do with who can smoke where. This section deals with where you can sell cigarettes or where you cannot.

**Mr O'Connor:** The key here, again, is that it's the patients who have the access to that and so it's not going to be a retail outlet that is open for employees. It's for the residents therein. That was something that was spelled out quite clearly. The key here is that it will allow us to allow for this exemption that will recognize the very serious situation as presented to us through these hearings and, at the same time, keep it consistent with the health facilities that will not be allowed to sell tobacco.

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So what we've done here is take a look at the need of the consumer, the person who is in the mental health facility, the mental hospital, and deal with them as separately as we possibly can, because it's not for the employees' benefit.

**Mr Sterling:** So rather than be practical and just take them out of the act, what we want to do is maintain this façade of a philosophy in a psychiatric hospital to prevent a few members of the staff going to the tuck shop and



buying a pack of cigarettes. Is that what you're telling me, Mr O'Connor?

**Mr O'Connor:** We're responding to something that was a very real issue presented to us by people who are advocates for the people who are in these psychiatric facilities. These people who came before the committee didn't make any sort of wish that they wanted to make it easier for the employees to be able to buy cigarettes in this type of hospital setting, this health care facility setting. The key here is that there are some people who are staying in these places who are quite vulnerable and susceptible to many different abuses, and part of the—

**Mr Sterling:** No one is disagreeing with you on that issue, Mr O'Connor. What I'm disagreeing with you on is this government's wont to create more ways to make regulations, which is absolutely ridiculous. Why do we have to create regulations as to who can buy cigarettes out of a tuck shop in a psychiatric hospital if in fact the cigarettes are there and they're there primarily because the people are incarcerated in the mental hospital and can't get outside to buy them? Everybody agrees with that. No one disagrees with you there.

My argument is, why are we creating more regulations in law when the practicality of those regulations and the intent to keep within the philosophy of this wonderful—

**Mr O'Connor:** Consistency.

**Mr Sterling:** —philosophy is so minute in comparison to the whole idea of setting this up? Who's going to watch the person who sells the cigarettes, whether they're selling to them to a patient or whether they're selling them to a person on staff? These kinds of laws beg people to break them.

**Mr O'Connor:** I think again there is consistency here that we're trying to keep the sale—

**Mr Sterling:** Yes, there's consistency that you like to make lots of regulations.

**The Vice-Chair:** Please allow the response.

**Mr Sterling:** Yes. Sorry.

**Mr O'Connor:** Here it's the sale to those individuals. People came to this committee and we heard those suggestions. They weren't suggestions that there should be a public tuck shop that would be operated in some health facilities and not others.

**Mr McGuinty:** I'm very concerned, and we have an amendment we'll be dealing with shortly which would exempt psychiatric facilities entirely from the ambit of Bill 119. I think the good news is that the government has recognized that it's important that people who are confined to corridors, so to speak, or hospital grounds or a psychiatric facility be able to have access to cigarettes. They are there for much longer than the usual three- or four-day stay in a hospital. They can be there for months and months on end, and if they are addicted to cigarettes, that is not the appropriate setting for people who are having extreme difficulties of a psychiatric nature to begin to force them to withdraw from that addiction.

I spoke with Marilyn Smith, someone who came before us—she was with the Mental Health Rights Coalition—and I passed the government amendment by her. She tells me that, to her knowledge, first of all, there are no

vending machines in psychiatric facilities, in the 10 institutions in the province, so that's not a concern.

But these do have tuck shops, and what she would like is that you don't change the existing system. It's working well. Let's remember what the intention of the bill here is. It's to make it harder in particular for young people to get access to cigarettes. Here we're talking about a lawful sales operation operating on the grounds of a mental hospital, and I just don't see the need.

Keeping in mind the intention of the bill, I don't see the need to impose this kind of regulatory scheme where now we're going to have to create some rules and regulations regarding how these things are going to be sold, and if you're a staff member: "Who's that for? Is that for you or is that for a patient? Well, if it's for you, you can't have it." Somebody else comes up: "Do you work here? No, I can't sell you cigarettes."

Those are the kinds of questions that somebody who's going to be selling these things is going to have to get into and I just don't think we need it.

**Mr O'Connor:** In an ability to keep consistent, "health facilities" is one area that has been stated. One of the people you referred to, Ms Smith, who came before the committee, also suggested that she wasn't too sure as to whether it should be the tuck shop or the canteen. Her concern, when she came to this committee, was for the person who is a resident in this type of facility.

I can see why you have some concern there and that's why I think there needs to be the ability for this regulation, so that we can take a look at whether or not it's going to then comply with the intent. The intent is that these people are vulnerable and that we don't need to make their lives more vulnerable. I think this will enable us to do that.

**Mrs Karen Haslam (Perth):** When this group came before the committee, its main concern was for the patients. They indicated that they had a canteen for patients only, and that's what they were suggesting, was to have those cigarettes available for the patients in that spot that was for patients only.

My concern would be that when you exempt this facility, we would then have another facility come in and say, "Everyone in our place has a broken leg and can't walk down." I see it as a growing number of health facilities asking for exemptions. I don't think the presentation from this group was to say, "Exempt this facility." That wasn't what they were talking about. They were talking about a particular place where patients could go for the patients to purchase the cigarettes. That's why I would hate to see us go just with the total exemption of this health facility.

I can understand that the government's trying to accommodate the group that came before us with a specific concern, but I would hate to go so far the other way for that specific concern and say that we exempt the total facility.

**Mr Jim Wilson:** It reminds me of the Sunday shopping debate when we were starting into size of stores and that fiasco, which eventually caved in on the government. Perhaps we could hear from the parliamentary assistant

what exactly the regulation is going to be. I'll even take what vaguely the regulation's going to be, because I think Mr Sterling makes a very good point. You have an exemption, for example, for psychiatric facilities, yet what makes someone in a nursing home less vulnerable than somebody in psychiatric home or, go to section 5, someone who's in a home for special care or, 6, somebody who's in a charitable institution or, 7, someone who's in a home for the aged or a rest home? They're all equally vulnerable.

Where there are smokers in those facilities, the point, I thought, of amending this section was to ensure that patients had access to cigarettes. We also are told, and I think we all believe, that health professionals help run these institutions, so let's let professionals be professionals and decide where they will place the tuck shop and who will have access to it, and the government could simply make its intentions known, and that is that it wants the sale of cigarettes restricted to patients where possible in these facilities. Otherwise, I hope you'll give us the regulation and then we can judge, as legislators, whether or not you're just getting into a quagmire.

**Mr O'Connor:** The key here is what we heard through the committee hearing process. We heard about some pretty terrible situations taking place in these type of facilities and cigarettes being used as a bartering system. If we were to restrict access to some of these patients we could put them at very severe risk, and that's the key here. I believe Mr Sterling even said that he felt it was important that we didn't place anybody more at risk going through these hearings.

**Mr Sterling:** But we have heard the same arguments. Quite frankly, when we go through this, I'm not going to vote for any of the sections, save 1, 2 and 8. When you're dealing with a psychiatric facility, a nursing home, a home for special care, a Charitable Institutions Act home, a home for the aged or a rest home, basically what you're talking about are people who can't get out easily to the marketplace.

1350

We heard from somebody in one of the homes for the aged and rest homes who said, "I have to pay twice as much for a tobacco product because I live in this place." Is it the intent of the government to burden these people with paying twice as much for cigarettes as somebody who would be able to walk down to the corner store? Is that your intent, to double the cost for these people?

Their argument, I'll grant you, isn't as significant as somebody who's basically incarcerated in a mental hospital, but notwithstanding that, their incarceration is because of a disability; they can't walk. You're going to penalize somebody who can't walk, is in a wheelchair and can't go down to the corner store? That's what you're saying here, "Why can't they go down to their little local tuck shop and buy their tobacco if they need it and smoke it in the area that is provided for them to smoke?"

I can't vote for any of those sections because basically what you're saying to disabled people is, "We're going to disfranchise you." That's what you're saying by having 3, 4, 5, 6 and 7 in this act.

**Mr O'Connor:** There is some consistency here when what we heard from the advocates coming here for the psychiatric patients was that they are in a very special situation. They are more vulnerable than somebody being abused in any number of long-term care facilities that you put up with. I don't believe that this type of abuse we've heard about should be tolerated. I hope it isn't, and I hope that something can be done about it, but it's a different situation. It wasn't something that we heard in these committee hearings.

**Mr Sterling:** We did. Read the Hansard for the last day.

**Mr O'Connor:** I appreciate it. I guess what we've got here is a difference of opinion.

**Mr Jim Wilson:** I think what Mr Sterling is pointing out is its absolute inconsistency. He's made a very good commonsense case there with respect to, yes, we had a number of advocates for psychiatric patients and facilities come to this committee, but that doesn't mean you put blinders on to what else is in this particular section, and that is, I think that wheelchair-bound residents of nursing homes are just as vulnerable as people who are confined to a psychiatric facility. I fail to see the logic of the government's approach on this.

I will go, of course, farther than Mr Sterling. I'll be voting against section 8, because I don't believe you should be picking on one part of the retail sector with respect to pharmacies, section 9, and I want an explanation also of section 10, which I asked for many times in the hearings. What's in the future? I do not like giving governments carte blanche with respect to a prescribed place or—what's the new wording?—a prescribed class. That means that you can not only, through this legislation, ban the sale of cigarettes in a number of places as listed, but then once this act is passed you can go and ban it wherever the heck you want. We're giving you absolutely sweeping authority here, and I want to know what you intend to do with section 10 when you're asking for such wide-ranging prescribing powers.

**The Vice-Chair:** Mr Wilson, those sections are not before us at this time.

**Mr Jim Wilson:** It's right before us, section 10. Read the amendment. Sorry, it's paragraph 4(2)10. So it is before us, and I want an answer to my question.

**Mr O'Connor:** In response to that, at this point there is nothing up our sleeve. What we have to do, though, is not tie the hands of future governments as they move towards an area and as society changes that are going to say we need to be more restrictive in the future. At this point, there is nothing before this government, and we just want to have that ability in there for regulations in the future that will be consistent with the way society is moving.

**Mr Jim Wilson:** The point is that you don't have to go back to Parliament then; you don't have to go back to the Legislature to ban the sale of tobacco products in more stores that you may think up in the future. I think that's wrong. I think it's a serious societal issue and society has the right to have its parliamentarians speak on further bans.



**The Vice-Chair:** Do you wish to respond?

**Mr O'Connor:** I've responded, thank you.

**Mr McGuinty:** I want to go back to the issue of the psychiatric facility designated under the Mental Hospitals Act. I want to get the government's intention on this. Are we trying to prevent a certain group of people from gaining access to cigarettes by regulating how they can be sold or where they can be sold?

**Mr O'Connor:** At this point, what we're doing is allowing for an amendment here that will point out the exception, which is those vulnerable individuals as pointed out to us through the committee hearings. Maybe you could clarify your question just a little bit more.

**Mr McGuinty:** What is it we're trying to do? You're going to regulate now where tobacco can be sold on hospital grounds, I assume, within the complex. What's the purpose behind that? We've agreed that the patients have to be able to buy cigarettes on the property.

**Mr O'Connor:** For some individuals in that type of setting, they don't have the liberty to come and go as in some other cases. This is part of what we've heard through this process, that individuals who are incarcerated and don't have the access to come and go be allowed the privilege of continuing to purchase.

**Mr McGuinty:** So if you're confined to the hospital, you'll be able to buy cigarettes there, but if you can leave the premises, then you'll have to buy them elsewhere, even though there's a shop right on the grounds. Is that right?

**Mr O'Connor:** Not quite. At this point, I don't think there's a differentiation under the designation of the Mental Hospitals Act that would differentiate between two different types of patients in the same facility.

**Mr McGuinty:** Then whom are we trying to stop from buying cigarettes through this provision?

**Mr O'Connor:** It's those who are vulnerable whom we heard the compelling evidence about.

**Mr McGuinty:** You're trying to stop them?

**Mr O'Connor:** To allow them.

**Mr McGuinty:** But whom are we trying to stop?

**Mr O'Connor:** The intention here is that they're not public shops for any portion of the public coming in to purchase them. It's to allow those patients who could be placed in a vulnerable situation to have access to tobacco.

**Mr McGuinty:** I just don't see many people going to Penetanguishene or Brockville or the psychiatric facility in Hamilton to buy their cigarettes.

**Mr Jim Wilson:** It would be a loss-leader sale, I'm sure.

**Mr McGuinty:** Let me move on to something else. Mr Wilson asked you what I thought was a direct question and I'd really like an answer so that when I'm talking to these people later today, they'll know what they'll be looking at. What are the regulations going to look like in terms of the location of these shops?

**Mr O'Connor:** I think that's where we do need to have a little bit more consultation. That's why we need that flexibility to put it into regulations. We're not about

to do that without some consultation with some of the people who have presented this concern to us.

**Mr McGuinty:** My final comment is with respect to the description of a pharmacy. It's extremely far-reaching, obviously. We're talking about a retail operation that could be, as we saw here, in excess of 100,000 square feet. There may be some 30 departments between the location where they're selling cigarettes and the pharmacy. What we are doing here in one fell swoop is categorizing the entire operation as a pharmacy. That's very far-reaching and I think it sets a terrible precedent. At some point down the road, because they're selling some other item in there, we'll say you're into hosiery sales, you're a hosiery operation, because you happen to be selling this stuff here, so we're going to describe the entire operation in that way. To categorize it in that way I think is just not the way to go.

1400

**Mr O'Connor:** I appreciate the difference of opinion here. There was a consultation that took place over a year ago when the draft legislation was put out in March 1993. The Ontario College of Pharmacists has been pretty consistent in its recommendations towards this, so I guess here there's a difference of opinion.

**Mr Sterling:** I hope that when we go through and vote after this particular amendment we will then have the opportunity to, when we go through this, as amended, to vote on each section. I would like each section recorded and an opportunity to debate each section as we go through it as well.

**The Vice-Chair:** Anyone further? If not, those in favour of government motion to amend subsection 4(2), paragraphs 3, 8, 9 and 10? Opposed? Carried.

Liberal motion to amend paragraph 3 of subsection 4(2).

**Mr McGuinty:** In fact, it was the very issue we've been discussing and my position is that we should be exempting psychiatric facilities entirely from Bill 119, that those patients who continue to have access to cigarettes in the same way that they have at the present time; that the hospitals continue to limit smoking in those areas that they have presently designated. I think there is no compelling reason here to alter the status quo. That's the long and the short of it.

**The Vice-Chair:** You're moving the motion, are you, Mr McGuinty?

**Mr McGuinty:** Yes, I am.

**The Vice-Chair:** Could you please read the motion.

**Mr McGuinty:** I move that paragraph 3 of subsection 4(2) of the bill be struck out.

**Mr Sterling:** We now have a new paragraph 3, which was just carried by the committee. So I assume it's as amended, is it, Mr McGuinty?

**Mr McGuinty:** No, this makes reference to the original Bill 119.

**Mr Sterling:** But that one's gone now.

**Mr McGuinty:** Then maybe we should have dealt with mine first.

**Mr Sterling:** What are we voting on, Mr Chairman?

**The Vice-Chair:** Is it agreed, then, that the motion as presented, the Liberal motion to amend paragraph 3 of subsection 4(2), is redundant at this time?

**Mrs Haslam:** Mr McGuinty did not vote in favour of the amended 3; therefore, this motion stands as it is. His original motion is to not have paragraph 3. He did not vote for an amended 3; therefore, this motion is in order, correct?

**The Vice-Chair:** Any further discussion on the motion to amend paragraph 3 of subsection 4(2)?

**Mr Sterling:** Perhaps we will deal with this as we go through the subsection paragraph by paragraph and record votes, and we can make our arguments at that point in time, because we will then be dealing with amended paragraph 3, as introduced by the government and just carried. I do want to indicate that we are against the amended version of this part of the amendment that was just passed by the government. In other words, we'll be voting against that for the reasons previously stated.

**The Vice-Chair:** Anyone else? All those in favour of Mr McGuinty's motion to amend paragraph 3 of subsection 4(2)? Opposed? The motion is lost.

PC motion to amend section 4 of the bill.

**Mr Jim Wilson:** The first PC motion that deals with section 4, and it has (a), (b) and (c) and an exception for veterans—we will not be introducing that, Mr Chairman.

**The Vice-Chair:** The first one will not be introduced.

**Mr Jim Wilson:** The next PC motion, I think, comes after the Liberal motion. Mine deals with paragraph 8; the Liberal motion deals with paragraph 7.

**The Vice-Chair:** The Liberal motion.

**Mrs O'Neill:** I move that paragraph 7 of subsection 4(2) of the bill be struck out.

The reasons for that amendment were also the result of what I considered very strong witness representation as well as much written representation that I had on this issue.

The homes for the aged and rest homes are homes. Some of the residents require some care but many of them don't. We had very strong evidence of the dangers that some of these individuals, particularly in the city of Toronto, encounter when they have to leave the residence to cross very busy thoroughfares to a variety store or whatever as they try to obtain their cigarettes. Many of them suggested that they don't have many visitors, and I think those of us who have had some recent experience in these institutions—they're really not institutions; I shouldn't use that word—homes, find that there aren't a lot of people visiting in these areas.

I feel quite strongly that these people have paid their dues. Many of them have taken up smoking as a result of their service in the military and they were paid in cigarettes. These are long-standing habits. These people are usually in their 80s; the average age is in the 80s, some of them are in their late 70s, and they came before us very strongly and said that as we had the right to smoke in our homes they want the right to smoke in their homes.

**The Vice-Chair:** Thank you. Comments, questions?

**Mr Sterling:** Yes, I strongly support Mrs O'Neill's motion here because of the evidence we heard in front of this committee. In fact, I think on the last day we heard that evidence from a resident of a home, that it was very, very difficult for him to get out of the home, particularly in the winter when there's ice on the roads and that kind of thing, to cross the street, to go to a convenience store in order to purchase cigarettes.

Perhaps the parliamentary assistant can answer this for me. If a person in a home for the aged doesn't have a relative who can go and get cigarettes for him, what is he or she to do? Can you answer that? How do they get their tobacco? Can you tell me how they get it?

**Mr O'Connor:** As local MPPs we sometimes have to draw analogies and look at our own ridings for examples. There is a large number of long-term care facilities within my riding that have no tuck shop, yet have residents there who smoke. So obviously there's the ability for them to get cigarettes regardless of whether they go down the hallway to purchase them or do it in another fashion. So the inability for the residents to get the tobacco products I guess would be the dilemma that some of these people face currently.

**Mr Sterling:** So you want to put more people in this dilemma? Is that what I am to understand? I mean, that's what you're saying. You're saying you want to put more of these elderly people, who have difficulty getting out, particularly in the wintertime, in the dilemma of not being able to buy tobacco, to which they are addicted.

**Mr O'Connor:** I guess "dilemma" is a poor choice of words, but I did say it.

**Mr Sterling:** So you stand by it?

**Mr O'Connor:** The point is what we're dealing with is—

**Mr Sterling:** God, I mean, where's the compassion in this government?

**The Vice-Chair:** Please, please.

**Mr O'Connor:** Thank you.

**The Vice-Chair:** Would you care to respond.

**Mr O'Connor:** Yes, I appreciated that, Mr Sterling, you had the opportunity to join us for a day of committee hearings and to develop all of your opinions based on a day or so. The fact is that this legislation deals with health facilities, and in this portion of health facilities there is the ability for smokers to get cigarettes at this point, whether they have a tuck shop or not.

**Mrs O'Neill:** I have a lot of difficulty with the definition of homes for the aged and rest homes as long-term care facilities. They are not. They do not fall in the same definition. Many of the residents do not require any care at all, especially under the rest homes act. These are people who are living communally. They are living there because they have given up their own properties for the most part, but many of them are going to the dining room to eat, they are looking after all of their own personal care. It is a case of not being able to be very mobile in the exterior, particularly in the climate we're in in the winter.



I feel quite strongly that this is not the same as a nursing home or a home for special care. You're putting all of these acts together. I don't know about your mailboxes—and the people who came here from the residents' council were very mobile people. They would not be the least bit appreciative of being termed people who need long-term care. It is not a health care facility in the same way that the other facilities that are part of this act are.

**Mr O'Connor:** As we went through this consultation and the consultation around the proposed legislation back in 1993, we heard people refer to these places as health facilities. At some points there are differences of opinion and we'll vote on them as differences of opinion. This was something that was pointed out to us on numerous occasions, that these aren't special exceptions as well.

**Mrs O'Neill:** I have a lot of difficulty that we have acts and they define a certain kind of living arrangement and that living arrangement is not being applied here. We are not talking about a health care facility here in the definition of the health facilities and professional act that I know. In any case, you say it's a difference of opinion; I say it's a difference in definition.

**Mr Jim Wilson:** I'm most disappointed in Mr O'Connor's condescending response to my colleague Mr Sterling. I think it was deplorable. Mr Sterling certainly deserves an apology. He has a nine-year record second to none on this issue in this Legislature.

**Mrs O'Neill:** That's true.

**Mr Jim Wilson:** He has worked very, very hard on this issue and is known outside of this Legislature as a leader.

We are trying to help you, Mr O'Connor, by putting some consistency in this act. Your own logic fails because you want to go ahead and pick on the frail elderly of this society, and you have no good excuse for it except to give a condescending response to my colleague. I think he deserves an apology from you right now.

**Mr O'Connor:** I don't believe there's anything due at this point. I guess we could look at the record for all the number of years that he was I think maybe at one point even a cabinet minister, when he could have brought forward this legislation.

**Mr Jim Wilson:** You can't win.

**Mrs O'Neill:** What an answer.

**Mr McGuinty:** I think a pattern has emerged during the course of the hearings. I think it becomes apparent that whenever you stray from the original intent, which is to make it harder for young Ontarians to get hooked to this terrible product, you get into areas of controversy. The only parts of this bill that are going to come back to haunt the government are those parts which—you're going to start to give elderly people in a home, for instance, a hard time to get their cigarettes. When normally they could buy them there, now you've closed up the shop. We didn't hear from the people who run those things in terms of the economic impact it would have, but I'm sure there would be some economic impact there.

Just to give you an example, and I don't have a heck of a lot of experience in this area, when I was practising

law I was appointed committee for two elderly women, sisters; one was 92 and one was 96. I was all they had in North American. They had no relations here. They'd come over here from across the sea and had worked here and retired and had become mentally incompetent. I would set aside a few dollars every month for them to spend at their home. Nobody ever visited them; maybe three times a year I'd have to, in order to see what was going on, but that was more out of a sense of obligation, to be very frank. I don't know what they're going to do now when you tell them that they can't buy their cigarettes in the facility.

It's a legal product. Again, we're not talking about concerns relating to secondhand smoke. There are designated smoking areas. We're just saying, "We're going to give you a hard time," and I don't see the justification behind it.

**Mr O'Connor:** I appreciate the concern you raise here. There are many different groups that go in to visit people who are in a number of different types of residences, whether they be rest homes or homes for special care or whether they be a long-term care facility. There are many different ways that people will have the ability to have access to this product. This section of the bill is to ban the sale in health care facilities, and I guess there is a difference of opinion here.

**Mr Jim Wilson:** I'm going to keep pressing on this issue because at some point logic should play into the law. In fact, the origin of law is pretty much along logical grounds.

Let me ask the question again: How can you say that psychiatric residents are more vulnerable than other people in rest homes and that sort of thing, and how can you discriminate against people who are in rest homes and nursing homes? How can you do that? It's not a difference of opinion. I think the public deserves an answer on how you can do that. Don't blame it on the groups that came forward. We didn't hear from every group in the world, you know; we heard from those that made the list, for goodness' sake. How could somebody in a nursing home who's confined to a wheelchair, who now can't even buy cigarettes, get down to this building to talk to us?

**Mr O'Connor:** I appreciate your concern. Given that all these types of facilities that are mentioned here do come under long-term care legislation presently, are you suggesting then that those long-term care facilities that I know of within my riding, and perhaps in your riding, should start selling them? Are you starting to say that we should be opening up tuck shops to sell cigarettes in all the ones that don't have them? I guess that's where there are differences of opinion. Maybe you think that opening up these tuck shops for the ones that don't have them is the appropriate way.

**Mr Jim Wilson:** I do not think you should be banning them, as you're banning the sale now. It should be up to those facilities. You have to be consistent across the board. I doubt you'll see in this day and age many of them open up tuck shops to sell cigarettes, but if that happened as a consequence, it wouldn't bother me. The point would be that they're serving the residents. I

appreciate the intent of your now-amended section 3, but you don't have any consistency with other facilities. That's the problem.

**Mr O'Connor:** I would say this is pretty consistent right through it where we're dealing with health care facilities. It's pretty consistent. The only exception is the fact that we heard that in the psychiatric facilities—

**Mr Jim Wilson:** There's no consistency.

**Mr O'Connor:** —these people don't have the ability to come or go, and we heard from the advocates saying that these people do not have the same amount of people who do come and visit these individuals, and they don't have the same ability. Those people were, as was pointed out to the committee, I thought in a much more vulnerable situation.

**Mr Jim Wilson:** What are people supposed to do if they live in a nursing home now, or a rest home, where they currently are able to get cigarettes in the tuck shop and you close that down when this act comes into effect and they're addicted to smoking and they're confined to a wheelchair and not easily able to get out of that facility? What are they supposed to do? That's the same issue we're dealing with in psychiatric facilities.

**Mr O'Connor:** I guess that here, for all those nursing homes and long-term care facilities within my riding now that do not sell them, here's a time where maybe—

**Mr Jim Wilson:** Tell me about those that do sell them. You can't ban something that doesn't exist. If they don't sell them now, it's irrelevant. It's those that sell them now, Mr O'Connor.

**The Vice-Chair:** Mr Wilson, allow Mr O'Connor to complete his response, please.

**Mr O'Connor:** Thank you. I suppose that in this type of situation where we're now talking about all health care facilities, maybe the honourable critic might be able to offer some advice and maybe network in his riding. But the fact is that this is consistent, that we are talking about all health care facilities being treated in a consistent fashion, with the exception of those very vulnerable people in the psychiatric facilities, as was pointed out to us.

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**Mr Jim Wilson:** But their vulnerability stems from the inability to leave that facility—right?—a psychiatric facility, to go elsewhere for cigarettes if they're not sold on the premises somewhere. That is their vulnerability when it comes to this act. We're not dealing with the Mental Health Act per se and definitions thereunder. We're dealing with access to tobacco products. Their vulnerability is the same as someone else's vulnerability in another institution, who because of physical incapacity or otherwise, cannot go outside the doors of the nursing home either.

I don't see the consistency here, Mr O'Connor. I do not see the consistency at all. You're talking about people who can't readily get access to a product they're addicted to. To me, it shouldn't matter whether you're talking about the psychiatric facility or the nursing home. So explain to me the consistency on that. Don't just say it's consistent, because it's not consistent.

**Mr O'Connor:** Paragraph 4(2)1, Public Hospitals Act, that's a hospital, a health care facility; paragraph 4(2)2, Private Hospitals Act; paragraph 4(2)3, psychiatric facility, dealing with the very real situation that was presented to us and there's the government amendment that we voted on; paragraph 4(2)4, Nursing Homes Act. There's something here. I think we're dealing with health care facilities. Paragraph 4(2)5, homes for special care, regulated under the Ministry of Health. It's a health care facility. Most of these fall under the long-term care bill that is directly under the Ministry of Health. They are health care facilities.

**Mr Jim Wilson:** In response to that, I'm just astonished that the parliamentary assistant to the Minister of Health doesn't know the difference between the Public Hospitals Act and the Private Hospitals Act and, as Ms O'Neill quite correctly pointed out, the other ones listed in 4, 5, 6 and 7, which are long-term care facilities. It's their homes for goodness' sake.

We're not arguing about banning the sale of tobacco products in hospitals and private hospitals. That's not what we're arguing here. They're a different category. You may call them all health care facilities, but they are, under the law, called long-term care facilities now, that dispense health care and look after the health needs of individuals, but it also is their long-term residence, which is entirely different in most cases than hospitals and private hospitals. Particularly when you've closed 5,400 hospital beds, they're not going to be anyone's long-term facility at all.

Now you've moved into an area where people have to live, like psychiatric facilities, where they're incarcerated, for goodness' sake, and you're taking away their ability to easily buy a product that they're addicted to. I can't understand how you make an exception for psychiatric facilities in your own amendment, but you don't make any exceptions for these other long-term care facilities.

**Mr O'Connor:** We've certainly had compelling evidence presented to this committee that these patients in these type of psychiatric facilities did warrant an exemption, given the very real scenario as presented to the committee by advocates for them. I don't think we can classify the two at the same time without recognizing that they were very real dilemmas that faced us. They're real serious situations and a situation over control of these products put people at risk. In fact, I know that your colleague supported them in that, and I think he probably would have moved to have this area struck if it wasn't included as an exemption.

**Mr Sterling:** What I can't understand here is that surely the difference between paragraphs 1 and 2 of subsection 4(2) is that are dealing with people in large institutions where people are coming and going on a daily basis. There are patients going in for short-term periods, coming out for short-term periods. People are visiting them on a regular basis. Some of them are quite mobile themselves to walk outside a regular hospital.

When you get into the other sections of this particular subsection, when you're dealing with psychiatric institutions, nursing homes, homes for special care, charitable institutions or homes for the aged and people who come



under the rest homes act, you're talking about people who are not mobile. We're talking about our elderly population.

No one is talking here about where these people can smoke in these institutions and where they can't. My assumption and I think everybody else's assumption is that there are smoking areas for these people to go and smoke in and that they obey those laws within those institutions. We're not talking about saying to these old people, "You cannot smoke in these institutions." We're saying, "Yes, you can smoke in certain places in these institutions and that will happen after as well as before."

But surely to God what you're doing in all these paragraphs is that in 4, 5, 6 and 7 you're dealing with the elderly population and the bottom line is, Mr O'Connor, you're going to make the life of the smokers in those institutions more miserable and more expensive because of these amendments. I will not vote for them and I will fight for those elderly people.

I really wish you'd go back and ask your minister whether she has thought about what she's doing, because I don't think she knows what these sections are about. I wish she were here today. Where is she? Where is the minister?

**Mr O'Connor:** I appreciate your concern about the whereabouts of the minister. We have had the opportunity, not only myself but my colleagues, to sit down and discuss this legislation with the minister and the minister supports this. I have to point to the long-term care facilities that I have in my riding that don't sell tobacco products. Are you saying that the way of life they've got there is that terrible, that those facilities that don't sell it now are by any way substandard to those that do sell it? The key here is that the people in the psychiatric facilities pointed out a very real and compelling argument to us that we responded to.

**Mrs Haslam:** We're talking about seniors and I keep thinking of the number of seniors now who stay in their own homes, with community care that comes in to them from all sorts of services that are offered. They have a slight disability in some cases to go outside their homes or fewer occasions to go outside their homes, but they still go outside their homes. They still are able to have someone bring them cigarettes perhaps or have somebody who would bring them that type of service.

I would look at the same senior in some of these homes who is mobile. I know there are services offered to some people in homes that say: "Let's go out on an outing. Let's go here. Let's go there." There are some people who take advantage of excursions and are able to leave the facility on a program basis offered by the homes. I would rather see us say no, no, no, rather than say no, yes, no, yes, no, yes. I would rather see us be a little more steady in what we're saying in taking a look at the health facilities and saying: "These are health facilities. There are some that don't have tuck shops in them that are capable and are operating quite well." All we're saying is that they are health facilities and we're limiting the necessity for a tuck shop to sell tobacco in a health facility rather than going back and forth and back and forth on the issue.

My other concern, and it might be a minor one, is that I'm not saying young people will find loopholes but I'm concerned that they're visiting grandpa and they go down to the tuck shop and say, "My grandpa is here and he sent me down for a package of cigarettes." The possibility of them saying in that tuck shop, "Okay, fine; here," is there and I would be concerned if we allowed that opportunity there too for young people.

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**Mr Jim Wilson:** I guess the point is that if you don't try and regulate what's happening now in these long-term care facilities—that is probably what the government wants. The witness we had speak to this from the veterans indicated that their internal policy at that hospital was to ensure that non-residents did not have access to cigarette sales in the tuck shop and there was a separate sales venue for residents only. That's what I think most people would agree is reasonable, and it didn't take legislation to do that, nor did it take saying that incarcerated psychiatric residents are somehow able to get cigarettes on premises but the frail elderly, "Well, you're out of luck."

Why would you want to put yourself in that position when what's happening out there now without any law is a positive trend, according to the testimony that was given to this committee? It still leaves a degree of common sense for people who are addicted. As someone said earlier, a lot of those people were addicted back when they were fighting for our country. It wasn't their fault. That was the way the world went at that time.

**Mr Sterling:** I was interested in Ms Haslam's remarks. I was interested in her saying that it's of greater importance to have this even principle over all these health care institutions than to have common sense. That's basically what she said. She said it's more important that we as a government say that we're going to have a rule than to have common sense. Now, if a government's going to go that far—

**Mr Jim Wilson:** They've gone that far.

**Mr Sterling:** —if that's their argument, I give up.

**Mr Jim Wilson:** Let's call an election.

**Mrs O'Neill:** We had a group here that was dealing with young people—I actually think they were from Etobicoke but I might be wrong—who were having difficulty giving up smoking. They had a drop-in centre. Difficult circumstances had led these people to seek a lot of supports outside their home. They told us that the best way to get these people off smoking was to help them regulate the smoking in the centre. I think you could remember that testimony.

We have residents' councils now as part of the long-term care reform, which as we like to remind people, has never yet really happened. We have a lot of promises, particularly monetary ones, that have not come forward. We have residents' councils, and what is their role going to be? They can't even decide in a home for the aged whether they're going to have a smoking area or not, whether they're going to be able to have cigarettes or tobacco in their tuck shop. The decisions the residents' council is going to be dealing with are already going to

be regulated. This is not the way to help people be comfortable in their old age. It's not the way to help them get along with each other either. I really do feel that this is again using a hammer to hit a mosquito.

**Mr McGuinty:** In terms of something that I feel confident ties all those together here, we've had the privilege of hearing from a number of presenters, we've gathered all kinds of information and I'd say we've acquired a substantial education in terms of the smoking problem in so far as it affects this province.

In terms of advancing the cause of, I wouldn't want to call it anti-smoking, I'd say pro health in this province, it's important that we make sure we bring people along with us. In anything you do, you want to create more goodwill than ill will, and it's these kinds of provisions that I think are going to hurt people who are out there on the front lines. That does, I would argue, the cause of health or anti-smoking a disservice. That's the kind of stuff that can backfire, blow up in your face and cause problems.

What I think the intent of Bill 119 should be, and I know everybody would agree with this particular aspect, is that we want to create a smoke-free generation. There are all kinds of people out there now who are hooked, and except for the issue of ensuring that people aren't harmed by secondhand smoke, there's not a heck of a lot we can do about those people, and just to make their lives more miserable I think does us a disservice, does the government a disservice and does the cause of health a disservice.

**Mr O'Connor:** I appreciate the opportunity to comment here. The fact is that we heard from many people through this process of committee hearings. We heard from people like the Canadian Cancer Society and the Heart and Stroke Foundation of Ontario. We've heard from the Lung Association and from many different communities across the province. We heard from different departments of health and health units. We heard from a lot of individuals. We never heard, though, I don't think, anyone saying this is a terrible way of life that people are living now in long-term care facilities because we are moving in this sort of direction. We are now talking about long-term care facilities, as health care facilities, not selling tobacco.

I don't recall the cancer society saying, "This is a very bad move. You shouldn't be doing this. This is a very terrible thing that you're doing." We never heard that from a health unit. The fact is that we heard from a lot of people and a lot of support for this legislation and support for all the members of the Legislature in bringing forward this legislation. We didn't hear, though, some of the arguments that have been presented.

I would have to caution you that I don't think I could go back to my riding as an MPP and suggest that all those long-term care facilities not selling cigarettes today are causing a real, undue hardship on all those individuals living there and that their way of life is that terrible.

**Mr McGuinty:** That's a stupid argument.

**Mr Jim Wilson:** That's the most naïve argument I've ever heard in my life, to expect the cancer society to

come forward and say what he just said it ought to have said or ought not to have said. That's ridiculous.

Secondly, long-term care facilities that are selling tobacco products are not selling them for the heck of it. These often volunteer tuck shops are selling it because there's a demand among patients. Maybe those who aren't selling tobacco products don't have sufficient demand to bother stocking tobacco products in the tuck shops. You should just leave well enough alone.

As we said, in what discussion we had at committee about this it seemed to me that there was a positive trend out there. People left to their own devices, health care professionals and patients and their advocates were coming to amenable and commonsense solutions to what they would see as a problem or as not a problem in their own institutions. I don't think it's your job at this point to come in, without a full debate on these sections, to suddenly place a ban.

**Mr O'Connor:** I just have to point out the consultation that took place prior to this. The draft legislation was put out there in March 1993. There was a consultation that took place. We heard from 240 individuals. We had oral presentations to people within the ministry from 34 different individuals, groups, representing a large segment of the population. This wasn't an area that raised a big concern, or as much of a concern as is being raised at this point in this debate.

**Mr Jim Wilson:** It strikes me that a lot of people who live in nursing homes aren't able to get to this committee to tell us their thoughts, first of all.

Secondly, Mr O'Connor, just because we hear presentations doesn't mean we've heard everything there is to hear about a subject. We know for a fact that it was difficult early on in these committee hearings to even get on the schedule of the committee, so I would hope you don't approach every committee hearing as if we're somehow locked into just what we hear at committee and we're to leave our brains at the door with respect to what's happening in the rest of the world outside these hearings.

**Mr O'Connor:** There again, I guess this is where there are differences of opinions. You feel we shouldn't be listening to, for example, those very vulnerable people. That's why we had the committee hearings, so that we could hear from some of the very vulnerable people in these psychiatric facilities who are put into very serious situations. That's why we had the hearings, so that we could hear from these people as they come forward and make these presentations to us.

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**The Vice-Chair:** Anyone else? If not, all those in favour of the Liberal motion moved by Ms O'Neill to amend paragraph 4(2)? Opposed? Motion lost.

The next amendment is the PC motion marked alternate 1 amending 4(2)8 and 4(3)8 and 9, I believe.

**Mr Jim Wilson:** I move that section 4 of the bill be amended by,

(a) striking out paragraph 8 of subsection (2); and

(b) striking out "paragraphs 8 and 9" in the third line of subsection (3) and substituting "paragraph 9."



It's clear from the amendment that this is an attempt to strike out the government-imposed ban on the sale of tobacco products in pharmacies; that is, it's an attempt to allow pharmacies that want to continue to sell tobacco products to continue to do so.

**Mr McGuinty:** I propose an amendment connected with this issue. We're going to be spending some time on the whole issue related to the sale of tobacco products in pharmacies. I think it was Mr Sterling who may have made the comment earlier on which I think was quite apt that we seem to be spending a great deal of time and energy on a topic which at the end of the day doesn't contribute significantly to the health issue in this province.

We didn't hear from anybody who said that banning tobacco sales in pharmacies will reduce tobacco usage. We talked about the symbolism, those who made the presentations talked about the symbolism, and how it just didn't sit right to have somebody who was making a living promoting health also selling a product which causes harm.

I don't want to rehash all those arguments as to who's right and who's wrong in this and what are the true feelings of the members of the college. We've heard from some on one side and some on the other side of this issue. If there's anything that's clear it's that there's no consensus. I think the usual is that if there's no consensus, you don't move.

I raised this question earlier and I want to put it again. I expect that there will be a constitutional challenge, that the argument will be made in court that it is simply not constitutional to ban the sale of a legal product from one particular retailer but allow it everywhere else. I think that constitutionally it is permissible to ban it everywhere but one particular facility, like the LCBO or our beer stores, but it's quite another thing to say everybody out there can sell it except you.

I'd asked the question earlier and I think counsel here had indicated that an opinion had been obtained. It may be subject to a solicitor-client privilege so we couldn't really release that information. The people of the province are the ones who are the client in this case, and they are the ones who are footing the bill to get the opinion, and I think we should be entitled to know what that opinion is. I'm wondering if we can have the results of that opinion.

What are our constitutional experts saying? What's going to happen at the end of the day when this is challenged, because I fully expect it will be? Are we going to win? Are we going to lose? And if we're going to win, why?

**Mr O'Connor:** I appreciate the comments made, and the client in this case is the Minister of Health representing the concerns for health for the province of Ontario. Information such as that is information that would be obtained for decisions made on the legislation, just as in many cases there is information that is gathered for any cabinet minister or the cabinet itself in making decisions on behalf of the residents of the province of Ontario.

That information is very important. Given that my

friend and colleague, who happens to be a lawyer, would know that you don't go into court with your books wide open and say, "These are all the arguments that we have," before you even have that opportunity to have a discussion, the opinion is that it falls right in with where we're headed regarding the health care facilities and that as a regulated health care profession, it fits in there as well.

The key here is in the discussion we heard from the college of pharmacy. The college of pharmacy doesn't represent the pharmacist but the people of the province of Ontario who go for that type of health care by going to a pharmacist. It's their opinion that it's in the best interests that these facilities shouldn't be selling them. You point out quite rightly that there isn't complete, full agreement, though I believe we've heard from the majority of people who are involved with that body saying there is an awful lot of support.

I would simply answer that this is another health care facility. It's something that is regulated through the Regulated Health Professions Act and it will be treated as health care professionals are.

**Mr McGuinty:** I'm sure my Conservative colleagues here will have some comments on that, but I want to come back to the legal opinion. I just want to ascertain this: An opinion was obtained?

**Mr O'Connor:** All information on any number of matters quite often will be kept for the minister or cabinet in deciding where to go from it. In some cases, and perhaps as you point out, if there is a court challenge, then that information, in the best interests of the people of Ontario, would be kept there. I would think that as a lawyer you could understand that.

**Mr McGuinty:** What if the opinion, Mr O'Connor, said, "Listen, there is no way on God's Earth that this is going to withstand a constitutional challenge"? I think that would be very important information for all of us to consider.

**Mr Jim Wilson:** That wouldn't stop them.

**Mr O'Connor:** It wouldn't be here at this point. At this point, we've heard, through the consultation process, many different opinions on a number of things. When the draft legislation was put out there in March 1993, we heard at that time from over 240 people making presentations and 34 making oral presentations to people within the Ministry of Health who felt this was a very important element to be included in this legislation.

**Mr Jim Wilson:** I just want to make clear why I don't support the government's ban on the sale of tobacco products in pharmacies. It really, in a nutshell, is because I'm not convinced and have not been convinced that prohibiting the sale of tobacco products in one part of the retail sector will in any way stop young people from starting to smoke.

Mr O'Connor, in our last round of debate, spoke about our having to listen to what was presented at committee. Nobody said it would actually reduce consumption. We heard a lot about that mixed message that perhaps pharmacists selling cigarettes—pharmacies, excuse me; it's often not the pharmacist at all who sells the cigarettes—

that pharmacies selling cigarettes sends a mixed message to young people. Yet we also saw polling that indicated that most people saw pharmacies as retail establishments and did not make the connection that was implied by many of the witnesses who told us that there was a mixed message with respect to the sale of tobacco products.

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But I want to go back to the legal question also, because it strikes me that there's a very good chance you won't be in government when that case proceeds to the courts, if it proceeds, and if this is gamesmanship, I think the government has to be forthright with people now. It's my understanding that there are some very good arguments and some very good reasons to take the government to court over this, and if you won't share the basis of the government's defence of this section, then I think that's awful.

I never thought I'd long for the days of Elie Martel and David Reville again, but I'll tell you that they'd be hanging from the bloody chandeliers if a Tory cabinet minister—and actually, cabinet ministers used to come to committee; we didn't have to put up with just having parliamentary assistants—had told them that it was a secret deal or it was a secret opinion; they'd have gone absolutely crazy, and rightly so. Now we're being told there's a secret opinion that may cost taxpayers a lot of money to fight this ban in the future, and the government doesn't want to share with its fellow parliamentarians the basis for its defence of this section. Shame on you, is about all I can say.

The minister may be the client in this particular case, but she is more importantly a minister of the crown and is a public servant. As such, since the cabinet decision has already been taken, I don't know why you can't possibly release the defence. It's beyond me. I can see your keeping such advice to cabinet secret on its way to cabinet, but once the decision is made and you're public with your decision, then the defence should be made public. It's beyond me.

**Mr Sterling:** Maybe there isn't any.

**Mr Jim Wilson:** Mr Sterling raises the point that maybe it doesn't exist. Maybe this is smoke and mirrors. Maybe you don't have an opinion.

Given that we can't get the government to tell us what its secret dealings are, I'd like to ask our impartial legislative counsel. There had been some cases in BC that I was familiar with on other topics in the last couple of years, and unfortunately I don't have the citation before me, but I thought it was not constitutional for the government to knowingly put someone out of business. Is legislative counsel familiar with what I might be referring to?

**Ms Sibylle Filion:** I'm afraid this is a question that's more properly put to legal counsel for the ministry.

**Mr Jim Wilson:** But legal counsel is in the pocket of the PA, so how am I supposed to get an answer? Okay, I'll try legal counsel. Frank, since the PA won't tell us, what's the basis of the defence here? You're a public servant, Frank.

**Mr Williams:** Without going much beyond what the parliamentary assistant has already said, I think I've—no,

let me finish my comments; you asked me. I made comments earlier to the committee that yes, I was of the opinion that there was sufficient authority, in our view, to go ahead with this particular part of the bill, and I still am of that opinion. As to why, I think that's the part that concerns the parliamentary assistant and myself, but certainly we are of the view that there is sufficient authority to go ahead with this section.

**Mr Jim Wilson:** You're not going to tell us why. Why can't you tell us why?

*Interjections.*

**Mr Jim Wilson:** Okay, let's do an abstract. If it was a parallel case, if your client weren't the Minister of Health, what would be the why?

**Mr Williams:** Very simple, without getting into any details in this particular instance, I know of a particular instance where a legal opinion was given that was passed on to an individual from somebody in the crown law office, and the particular opinion ended up finding its way to the group that was challenging a particular piece of legislation. When it got to court, everybody knew what the arguments of the crown were.

Certainly, if you want to support a bill and you support a particular part of a bill, you would want to see it supported to its fullest extent. So to that extent, I would think that as legislators you wouldn't want to jeopardize any sections that you happen to support. In any event, it would be protected under freedom of information, so I would be precluded from divulging that, even if I wanted to. That's really the simple answer.

**Mr Jim Wilson:** I appreciate that, and I knew you'd get to that simple answer eventually, which the parliamentary assistant should have pulled out of his hat, because he'd have been a lot safer pulling that one out first. But none the less, in roundabout terms then, it seems to me that if you can't divulge the opinion, you're breaking new ground. Would that be true? You must be breaking new ground with this ban.

**Mr Williams:** No, I don't think so.

**Mr Jim Wilson:** Then why would it be so secretive and you can't reveal it to a possible opponent?

**Mr Williams:** I stated earlier, and I'm not reluctant to state it again, that yes, we're of the opinion that constitutionally it's supportable. As I also mentioned earlier, the courts have not supported economic arguments as being a constitutionally supportable venue that the courts have looked at. They'll support race, religion, sex, a whole bunch of categories, but economic interest has not been an area that the courts, at least the Supreme Court of Canada, have traditionally supported. On the basis of what I said earlier and in those generalities, we're of the opinion that the section is viable.

**Mr O'Connor:** Just on the element that Mr Wilson had mentioned about no one saying that limiting the number of access points to tobacco products has anything to do with the amount of consumption, we did hear from many different health units the opinion that it could. In fact, the Addiction Research Foundation came before the committee and suggested that by limiting the number of access points to tobacco products, you also have an effect



on the consumption in that you would lower it.

**Mr McGuinty:** I know that a number of presenters offered that opinion, but really I think it's completely unrealistic. The only number I ever got was that there were about 120,000 retailers in the province selling cigarettes. What are we talking about, less than 2,000 pharmacies? Only half of those are selling cigarettes now. I just don't think this is going to put any kind of a dent in terms of accessibility, and I think it's unrealistic to speak in that regard at all. I think the only connection here is the symbolism. I myself find that just pretty tenuous.

The other comment I wanted to make is that legal counsel suggested that a good reason for holding back an opinion is because you're going to release information to the other side. I don't agree with that at all. In these cases, everybody gets to know what the other side's arguments are going to be before they get to court. You either read about it in the paper or you read about it in written arguments, so it's not a case of surprising the other side with a particular argument. Either you've got it or you don't; it's as simple as that. You take your best shot when you appear before whoever's going to decide the matter.

I don't think it's appropriate to hold back information because you don't want the other side to find out what truths you happen to be holding on to. You do want to hold it back, though, if what you've got says, "We're in trouble." That's when you want to hold it back.

**Mr O'Connor:** There's always room for a difference of opinion in debate. I guess that's what debate's about. The fact is that we heard from many presenters. We heard from a large number of pharmacists, either pro or against the ban, as a health care facility and as health care providers, whether or not they should be selling this lethal product. We heard quite varied opinions on the sale of this product through them.

**Mrs Caplan:** There are a couple of comments I would like to make on this section. I start from the premise that it is the responsibility of legislators to make laws and for the courts then to rule on whether those laws achieve their goals in a way which is acceptable through the court system. Laws that are made are always being tested and challenged. Particularly since the advent of our Charter of Rights and Freedoms, laws are being challenged in ways that they have not been challenged before. I believe that's good and that it is a very important and dynamic part of the process.

It seems to me, however, that what the courts may do at a certain point in time shouldn't be the only consideration when determining what is good public policy and what would be good lawmaking. It also seems to me that when you have the College of Pharmacists, which is the public interest governing body of a professional organization, in this case health professionals, saying that it believes it would be in the public interest to not permit pharmacies to sell tobacco and tobacco products, this is a very strong statement from a public interest body that lawmakers should be very interested in and, more than interested in, should respond to in a positive way.

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I think that the Ontario College of Pharmacists has taken a leadership role in its recommendation to the Ministry of Health and the government. I know that it's taken a leadership role which is not one that is supported by every member of the pharmacy profession. We know that in a recent questionnaire and a poll that was taken about 60% of pharmacists do not support the position of the college and 40% do. But it is important to remember that it is the college of pharmacy that has the public interest mandate given to it by the provincial government as part of the regulated health professions legislation. As such, their opinion on what is in the public interest, what will raise the public consciousness to the hazards of tobacco, I think should be a general theme as we discuss this particular part of the legislation.

Why did the college of pharmacy, on behalf of the pharmacists, come forward with this regulation? Because they believe, as health professionals, that pharmacists have an obligation to act in a way which is going to improve or maintain good health for their patients, for their clients, and because they are also retailers, for their customers.

Whether, as an end result, this part of the act is as successful as we would all hope it would be remains to be seen. You never know, when you draft legislation, whether or not your goals and objectives are going to be achieved. But again, just as you don't know what the courts are likely going to rule on the legislation until after they've had a chance to do their thing and review it, similarly you don't know whether the public policy imperative of the legislation is going to be achieved until you have a chance to see it in place and see if it is working as it was intended.

The reason I enjoy very much my opportunity to participate as a lawmaker in this province is because laws are not carved in stone. They are subject to change and amendment and debate. Lawmaking is ever evolving as you have the additional information of: Is it working? Is it not working? Is it having the intended effect? Did the courts strike down a certain section? Do we have to look at it and work at it again?

I feel it's important we remember that at this particular time and during this debate, because legislation is never perfect and it is never the best solution. In my view, you can't legislate behaviours, but what legislation can do is have a dramatic effect on improving the public's consciousness and the public's education about the matter which you are legislating. If, through this legislation, the message is sent, particularly to young people but to the public in general, of the serious effects of tobacco use and particularly cigarettes, then the public's interest will be well served by this legislation.

It's my hope that it will achieve the goals that are stated. It's my hope that the courts will find in the future that the legislation is in order and stands the tests of the charter. But it's also my view that if that change occurs in some way in the future, legislators will attempt to find other means to achieve the important public policy objective to encourage young people not to start smoking and to encourage older adults to quit.

It's with that thinking that I very much support this

attempt to achieve the goals of the college of pharmacy. I think they should be commended, as we have said before at this committee, for coming forth with this recommendation, which has a deleterious and serious economic impact, potentially, for some of their members, although we know many pharmacists have already chosen to not sell cigarettes, and we've heard from those that in fact there has not been a serious negative economic impact. So even that remains in question. But the college of pharmacy has taken a bold step and the government I think has responded quite appropriately to the public interest body which represents health professionals in this province who also happen to own and operate pharmacies.

It's interesting to note that we have given pharmacists a monopoly. They are the only ones able to own and they must own a 51% share in all pharmacies in this province. So when the college of pharmacy says, "We believe that our health professionals, our pharmacists, have a special obligation to guard the public health," it seems to me it is very appropriate for a legislative committee to consider that in its entirety when considering the legislation.

I will be supporting that, even though I have concerns about what might happen in the future to the legislation in the courts. I have concerns whether or not this is going to be sufficient to achieve the goals and objectives of the college of pharmacy, but I think it is a worthwhile step at this point for those people who are interested, as the college of pharmacy is, in good public policy that will achieve a better health status for the people of the province of Ontario.

**Mr O'Connor:** There's very little I can add to that. It was a very compelling argument, and if I wasn't convinced already, you certainly would have convinced me.

I guess the key that we heard through this argument was that we heard from not only pharmacists present but even from the young students going through to become pharmacists that their wish was to be linked with health care, with being professionals and trying to promote wellness, and they really did find it contradictory that when we're talking about good health, health care professionals would be condoning the sale of a product that when taken as directed can be lethal. I appreciate the comments from my colleague. Any further questions?

**Mr Robert Frankford (Scarborough East):** This is the first time I've been on this committee and I've listened with great interest to the contributions. If I could make a general comment just to reinforce why this legislation is thought necessary, we are talking about health issues and significant common health problems. We're talking about a number of forms of cancer, but I think we shouldn't forget obstructive lung disease, arterial disease, complications of diabetes. These are all things which are well documented as severely exacerbated by cigarette smoking.

When we remind ourselves of this, it just becomes obvious that there's a profound conflict if we expect pharmacists to be profiting from cigarettes. On reflection, it really is totally inconsistent if you have a chronic bronchitic patient you're providing expensive antibiotics and bronchodilators to and you're selling them cigarettes.

I think that must be the reason the pharmacists have taken this very good initiative to say: "There is a conflict. We have to be professionals, we have to profit from using our training, and our mandate is the promotion and preservation of health."

I hope that everyone understands and that we can really proceed, with the legal reassurances that this is likely to withstand any challenge, that the college is there to promote the public interest by statute. This is something which will make a very profound step for the control of tobacco, for the reduction of disease, and we should commend those pharmacists who have already taken that step, who have in most cases found they have not suffered financially from it in any case. I'm sure this powerful legislation will stand.

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**Mr McGuinty:** My colleague Mrs Caplan has spoken in regard to this issue and made some very important comments, and as a former Minister of Health she brings considerable experience to the issue. But I want to make sure that the concerns expressed by a significant proportion of the members of our caucus do not go unheard or unannounced. That is the concern relating to the economic impact of the ban—I think my motion will go at least some length towards addressing that—and the fairness issue in terms of telling pharmacists what they can and cannot sell even though we're dealing with a legal product.

I guess this is seen as a government being overly intrusive when at the end of the day, again, we're not going to reduce accessibility to cigarettes one iota. I just wanted to put those on the record so we're clear as to the difficulty that this issue has presented for us as a caucus. I hope my amendment will be adopted by the government. I remain very optimistic of course, Mr Chair, and I look forward to dealing with that very shortly.

**Mr O'Connor:** I appreciate the views and concerns. I have no doubt that there are many people who are concerned about the possible economic impact. In fact we heard from many pharmacists who stated the case that, after having gone through some soul-searching and deciding to break themselves free of the tobacco sale habit they had, they've been able to do so and find other products that they can sell and to target other things that were more related to the health care aspects and elements of their profession. So I appreciate hearing your concerns.

**Mr Jim Wilson:** I appreciate, as always, Mr McGuinty's comments, but I do want to clarify the fact that his amendment simply extends the time at which the ban would begin to take effect. This amendment bans the ban altogether. I just want to clarify that.

**The Vice-Chair:** No one else? All those in favour of the PC motion moved by Mr Wilson to amend paragraph 4(2)8 and paragraphs 4(3)8 and 4(3)9? Opposed? Amendment lost.

The next is a PC amendment to subsection 4(3) headed alternate 2—alternate 3. I believe it's been changed.

**Mr Jim Wilson:** Yes, Mr Chairman. I move that subsection 4(3) of the bill be amended by striking out "first" in the fourth line and substituting "third."



The effect would be to ensure that the ban on the sale of tobacco products would not take effect until the third anniversary of the day that this section comes into force. In other words, it would give approximately three years before the pharmacists would be prohibited from selling tobacco products in their stores.

**Mr O'Connor:** I don't believe this amendment will get support. I know it won't from the government members. We heard many people saying that the period should be shortened and not lengthened. So the government will not be supporting this motion.

**Mr Jim Wilson:** May I add to that? We heard almost as many people saying it should be lengthened and not shortened, so I suppose we have a difference of opinion on that, Mr O'Connor, as you oft quote. The fact is that with the government totally ignoring the economic issues with respect to this issue, I was hoping the government would at least give those pharmacists who did the Coopers and Lybrand study, who supported it, those people who believe there will be an economic impact, some time to adjust to the new law.

I know that in government amendments, in fact, we are going to have a shorter period with respect to phasing in the ban and I think that's wrong. I think the government should move towards a longer period to allow pharmacies to get out of the business of selling tobacco products over a reasonable period of time—and I think three years is a reasonable period of time—given the numbers we are looking at, given the fact that we're going to see a tremendous job loss. The Coopers and Lybrand study indicates that.

You can minimize the effect of job loss on this part of the retail sector by allowing a longer phase-in period of the ban or phase-out of the sale of cigarettes, however you want to put it. I was very much hoping the government would consider that, Mr O'Connor.

**Mr O'Connor:** I appreciate your comments.

**Mrs Haslam:** This reminds me of the 10-year-old child who knew at 7 o'clock that bedtime was at 9, who knew at 8 o'clock that bedtime was at 9, who knew at 8:30 that bedtime was at 9 and at the last minute is saying, "Half an hour more, mom, half an hour more."

They have known for three years that this is coming, they have known for another year that the government was introducing legislation and was holding consultations on it and at the last minute they are saying, "A little bit longer, a little bit longer."

I don't think this is the way to go. I think we're all very cognizant of the amount of time that's already been spent on this. They do know this is coming forward, they have known for a long, long time this was coming forward, and I can't see us extending it.

**Mr McGuinty:** My amendment is very similar, only I propose that the ban come into play two years from the date that this section comes into force. The Conservatives are talking about three years and I think two years is more appropriate.

To pursue Mrs Haslam's analogy, we're talking about the child who was told that it was 9 o'clock, but what's happened here is that through the amendments the

government has told the child it's now 8:30. It started off with the first anniversary and now they're telling us, through their amendment, that it's going to be the end of this year.

**Mrs O'Neill:** Right on.

**Mr McGuinty:** You've abbreviated the time frame and, frankly, I can't see how you did that. This particular issue was so controversial, I think the best you could have done was to leave it alone. You're rubbing salt in the wound by curtailing the period even further.

**Mrs O'Neill:** Compressing the time.

**Mr McGuinty:** The important point here is that there's an economic downside, and I think we would be wilfully blind not to recognize that. We have had some studies prepared by outside parties. It would have been nice to be able to compare them with a government study, but there was no such study, so the best we have is what we got from the outside.

Intuitively I think we all can recognize that if you cut down sales in any particular retailer, of the percentage that we're dealing with here when we're talking about cigarette sales, there's going to be a downside. I think the least we can do is call for an adjustment period.

The Conservative motion here, as well as mine, recognizes that the government plans to go ahead with this. We're just talking about doing it in a more civilized and humane way to allow for adjustment.

**Mr Jim Wilson:** Mrs Haslam's story was a nice little story, but I think the story ignores the very serious repercussions that we are told will occur as a result of the government imposing a ban on the sale of tobacco products in pharmacies. It seems to me that it would be more reasonable, given that on the one hand the government fills our media and print media with stories about how concerned they are about jobs, and on the other hand in committees like this they don't seem to even flinch a eye when it comes to cancelling a few jobs or a few thousand jobs, depending on who you believe.

1520

We know there will be job loss. I think you'd have less job loss if you gave a longer period of adjustment. I think you have to realize, in case you don't realize—the polls should tell you something—that a lot of people out there are absolutely in disbelief that you would move ahead with this ban, that you would not recognize the rights of the entire retail sector and that you would move to discriminate against one set of retailers for whatever reasons.

I think that while you say they've had lots of warning—I guess that's the moral of your story, Ms Haslam—the fact of the matter is a lot of people just can't believe that a government, during a recession, when people are starving and out on the street, would want to throw more people out on the street.

It's very, very difficult for people to understand that. Therefore, now that you've moved ahead with the ban, though, you should try and minimize its effect and its economic effect on those people who will be hurt by this ban in a three-year or a two-year period, as the Liberals are suggesting, but certainly a three-year period is the

most reasonable approach. I just want to know, Mr O'Connor, don't you care about the job loss? Do you have no thoughts on that whatsoever? Please tell me what you're going to say to people who lose their jobs under this bill. I want to know because I'm going to have to tell my constituents this too.

**Mr O'Connor:** I appreciate this debate taking place at this point. You will recall that we heard from—I guess I'll give you a couple of examples—the Tobacco-Free Thunder Bay Coalition, there was Dean's Pharmacy, and I believe that was out of North Bay, that suggested we reduce the amount of time.

In fact there were a number of people who suggested we go to a 90-day period, and I'll give you some idea of who those people were. They were the Ontario Campaign for Action on Tobacco, the Ontario Public Health Association, the Toronto department of public health. There were numerous suggestions that we go to 90 days to be consistent with the vending machines, to bring it down to 90 days.

Frankly, that is a concern. It's something that we had to deal with and think about. So in dealing with this, we notice even though there is a ban on vending machines in public places through the federal legislation, there are many places in the province where we see those vending machines take place, sales still in operation in places that they shouldn't be.

December 31 to me would be a natural date. You know, it's the end of the calendar year and fiscal year for many people. It's a date that makes much more sense than picking one two, three years down the road. The two, three years down the road, I guess you could say that's what the college has done. Two or three years down the road, beyond, it's been something the college has been talking about since the late 1980s in trying to go to the pharmacies and their member pharmacists, in trying to get them to recognize that it's really inconsistent.

I guess there are many different things that needed to be looked at and it wasn't something that we took lightly for those people who suggested we shorten that period to 90 days. So I appreciate Mr Wilson's concern.

**Mr Jim Wilson:** I think December 31, 1994, may seem like a natural date for a government that doesn't know anything about business, but it's not, for most businesses, anything to do with the business cycle. I mean, very few will have sales closing dates on December 31, 1994. In fact it just shows you don't understand anything about the retail sector.

It begged the question throughout the debate when a lot of the groups were asking for the ban. We should have asked each and every one of them: "Do you know anything about the retail sector? Have you ever run a store?" They had a different reason for asking you for a 90-day imposition of the ban.

The fact of the matter is there will be a job loss. You did not answer my question. I don't think throwing back these interest group names at my constituents—their eyes are going to gloss over. If I were to say, "Well, in fact, they asked for a 90-day ban," anyone on my main street

would definitely say you shouldn't pass laws unless you know anything about business, and particularly if you're dealing with a retailers' law.

The date you pick is nice, but it's got nothing to do with reality. Maybe it helps the government, although government's year-end isn't until March 31, so I don't know where December 31 naturally plays into it. I still don't understand why you wouldn't allow pharmacies—now that the decision is in law or will be in law to ban the sale of tobacco products—why you wouldn't want to take a reasonable course, minimize the job loss, and at the end of the day still have it your way. At the end of the day you'll still be banning the sale of tobacco products, but you're allowing that retail sector to adjust over a reasonable period of time.

Even those pharmacists who have already voluntarily banned the sale of tobacco products in their own pharmacies told us that they put a lot of thought into it, that there was adjustment, that they had to find other niche markets to serve, that they had to bring in other products. You've ignored the testimony even of those people who told us that there is a way to do this to minimize the economic loss but it takes time.

In fact what you're doing, as has been said, is adding salt to the wound by shortening that adjustment period, because you've picked some airy-fairy date out of the head that you say is natural. Well, it isn't natural at all. It won't make any sense to the retail sector.

If you're going to impose these type of laws, you have to at least do the courtesy to those you're restricting. For a few short seconds, put your feet in their shoes and what they're going to do. I think you owe that to these people. You owe that to these people who are entrepreneurs who put their money forward. They're not a bunch of socialists. They employ people in this province, and in fact your own Premier's running around saying, "I'm counting on those people to put Ontario back to work."

That's very nice. Where's the Premier today to defend this particular clause in this bill? He's not here, is he? I doubt he would defend it if confronted with the job loss information that this committee was presented with.

**Mr O'Connor:** I can point out that the Canadian Pharmaceutical Association, I would think, is a pretty reputable business.

**Mr Jim Wilson:** They're not a business at all. They are representing the public interest. They're not there for retailers.

**Mr O'Connor:** They represent many people who are involved in representing the pharmaceutical people in that type of area. The Physicians for a Smoke-Free Canada, who came to this committee, have suggested that there be a 90-day period. I think for most business people, they'd like to see a date, something they can actually plan towards, not a date for some time yet to be mentioned.

If we can look for example to the federal legislation on this issue, they never gave, for example, the vending machine industry a date. They said upon proclamation, that's the date that vending machines in public places will be banned, which happened the day they proclaimed it. What we're suggesting here, and we'll get to it a little



further in our debate, is that there be a set date so they've got actually something to work towards, to plan towards. They know where this will be. They'll know that come December 31, they have something to work towards.

**Mr Jim Wilson:** Why wouldn't the same logic apply to a date three years from now? If you're trying to speak against the motion, you're speaking in favour of it, I think.

**Mr O'Connor:** I guess that's the argument we heard repeated many times over—

**Mr Jim Wilson:** By a bunch of non-retailers.

**Mr O'Connor:** —by people, that what we need to do is to realize that the public interest body, the college of pharmacy, has been telling pharmacists for a period of many years that they should be working towards the elimination of tobacco product sales in their stores.

**Mr Jim Wilson:** And they are.

**Mr O'Connor:** It's something they've been talking about for a long time. At this point they've come to the government because they feel: "We've done all we could. We've tried the best we can to convince some pharmacists who sometimes don't understand that we're health care professionals." It was certainly evident from a large number of them as well who recognize the fact that they are health care professionals and have taken the steps necessary to eliminate the sales.

We heard from the students going to university today studying pharmacy that they wanted to be part of a pharmacy that wasn't dependent on the sale of tobacco products. By having a fixed date, they've actually got something to plan towards. It certainly is consistent with what they suggested, because it's something they've been suggesting for years.

1530

**Mr Tony Rizzo (Oakwood):** Sometimes it seems that the members of this committee attended different meetings during the last month. My recollection is that in London, in Ottawa, in Thunder Bay, in Sudbury, everywhere we went, pharmacy owners who have chosen not to sell tobacco in the past didn't experience any reduction in business whatsoever. I think we're indulging in political rhetoric when the experience is that people are dying every day because of the use of tobacco. This has been the experience.

As a matter of fact, I remember in the first few days my tendency was to allow pharmacists another year or more, but I was convinced by the deputations of people who were in front of us during those few weeks and I changed my mind. I tried to support a motion that would decrease the amount of time we had to wait to implement this legislation rather than vice versa.

**Ms Jenny Carter (Peterborough):** I just wanted to say I think Mr Wilson is understating his case that selling tobacco creates jobs. It creates jobs in other ways, because when people get sick or die relatively young, then they are leaving jobs that would otherwise have been occupied that become available to other people. Of course, they're also creating jobs for doctors and hospital staff and people in the medical services.

**Mr Jim Wilson:** I just wanted to—

**Mr Donald Abel (Wentworth North):** He's lost for words.

**Mr Jim Wilson:** No, I'm not lost for words at all. It's a legal product. You're discriminating against one part of the retail sector. The only evidence we had was that jobs will be lost and it was mostly to do with not the tobacco sales but the ancillary sales that accompanied someone coming in and buying a pack of cigarettes.

**Mr Frankford:** It's a toxic product.

**Mr Jim Wilson:** You guys have made up your minds and I guess I've made up my mind and we're going to debate it until hell freezes over.

The fact of the matter is I did want to ask the parliamentary assistant, because I've cited a couple of occasions where, just because the college of pharmacy asked for something, this committee has not suddenly felt compelled, because it was in the public interest, to do it. Remember back to the Regulated Health Professions Act? There were all kinds of things. In fact, if anything, you agreed less with what they wanted. They got less from you than what they were demanding.

I remember during the sexual abuse legislation, they did not want to be considered a health care facility. I've re-read the transcripts. They made it absolutely clear that they didn't want to be responsible for perhaps the young cashier at the front of the store, who sells the cigarettes by the way. Most of the time it isn't the pharmacist at all; he's at the back of the store.

They didn't want to be responsible for any obscene language or non-politically correct, or as we used to call them, dirty jokes that someone might tell at the front of the store. Under the act, that was recognized. It was only in dealing with the pharmacist that there was a professional relationship between patient and pharmacist and it was only those actions that would be considered under the act.

It seems to me that there are lots of examples. It's nice to hang your hat on the fact that the college asked for it, but there are lots of examples out there where they've asked for something. This Legislature has a broader responsibility to the public. We have a responsibility to retailers. We have a responsibility to people who are jobless now and who may lose their jobs. That it seems is being ignored because of a very tunnel vision approach that the government's taking on this section of the bill.

**Mr O'Connor:** I guess I only point out that when we heard from the students of pharmacy, they pointed out that they wanted to work as health care professionals, as people out there promoting good health and trying to make people healthier, and they've seen the sale of tobacco products as something that was in contradiction. It's not what they went to school to learn. They didn't learn to blend tobacco products to make people well.

Tobacco products, cigarettes, when taken as directed, certainly aren't something that is going to make people healthier. It's not just the college that has made that argument to us. We've heard from the students of pharmacy, for example. We heard it from many, many people in relation to this issue about whether or not they are health care professionals. I guess from there again there are

points where we come up with differences of opinion.

**Mr McGuinty:** I just wanted to make a point about the non-traditional pharmacies, because I think the impact the ban will have on them is more significant, stores like Zellers, K mart, A&P, Woolco, Loblaws, whoever else out there. My notes show there are 160 of these in the province now.

In terms of just their prescription fees, many of these actually use those kinds of fees as loss leaders. They're charging very little. Some of them charge nothing, the idea being of course to get them into the store and get them to spend money on other items. There are 183 full-time pharmacists, 199 part-time pharmacists, and then there are pharmacy assistants, who've received special training, 69 full-time and 192 part-time.

Now, if you're running Zellers or Loblaws, I think the decision at the end of the day is going to be that you're going to have to get rid of the pharmacy—you're not making any money on that anyway—and stick to the cigarette sales.

That means those pharmacists, close to 400 pharmacists when you combine full-time and part-time, and those 260 pharmacy assistants are going to be out of work. They will not be re-employed within their employers' operations at the present time because they're getting rid of the pharmacy operation completely. Those people are going to be put out of work, and there's no two ways about that, there's no way of softening the blow. They're out.

We had a young fellow here, I can recall. I asked what he's going to do. He said he didn't know what he was going to do. He had two kids, his wife wasn't working, and he had no option, unless pharmacists are going to expand for some reason in this province and pick up those 400 who are going to be put out of work out of non-traditional pharmacies.

This is going to spell hard times for them, and I just don't see any answer for that other than, if you're set to ban tobacco sales in pharmacies, to string it out a little bit, to extend the period of time over which the ban is going to take place so they'll have time to adjust and look elsewhere.

**The Vice-Chair:** No other comments? The committee has before it a motion moved by Mr Wilson to amend subsection 4(3). All in favour? Opposed? Motion lost.

Next is a Liberal motion to amend subsection 4(3).

**Mr McGuinty:** I move that subsection 4(3) of the bill be struck out and the following substituted:

"Temporary exception

"(3) Subsection (1) does not apply with respect to the designated places described in paragraphs 8 and 9 of subsection (2) until the second anniversary of the day this section comes into force."

1540

Briefly put, we've been discussing this now at length. The Conservative motion provided for a three-year delay until the pharmacy ban kicked in. The Liberal motion provides for a two-year period before the ban takes effect. For the same arguments I've already made and put

on the record, I think it's appropriate that we extend the period of time to allow for adjustment by those who are going to be affected by this decision.

**Mrs O'Neill:** I think this is certainly worthy of very serious consideration and then support. The people who are most affected by this have had the opportunity as well of, and we saw that they had been, watching these hearings with a great deal of diligence.

In some cases the pharmacists who have already made the transition gave some very constructive ideas, and this particular amendment that we bring forward gives people that opportunity to think that over seriously, perhaps to seek some advice from those who presented and then to do what the bill will request that they do. But this just gives people flexibility. It accepts reality that we are in a very difficult time, that people downsizing, becoming unemployed is far more frequent than we wish it were. We just feel that two years gives a lot more time for people to explore their alternatives and to protect their employees.

**Mr Sterling:** In spite of the lack of Liberal support for Mr Wilson's amendment, Mr Wilson and I will support a two-year phase-in for all the reasons Mr Wilson outlined for a three-year phase-in.

**The Vice-Chair:** We have a motion moved by Mr McGuinty to amend subsection 4(3). All members in favour of the amendment? All opposed? The amendment is lost.

The next is a government motion to amend subsection 4(3).

**Mr O'Connor:** I move that subsection 4(3) of the bill be amended by striking out "the first anniversary of the day this section comes into force" in the last three lines and substituting "December 31, 1994."

This is for all the reasons I've pointed out previously and for all those compelling arguments that were made before this committee by the many deputations.

**Mr McGuinty:** I can't think of any other way of describing it than to say the government is pulling a fast one here. It put forward legislation, Bill 119. We had presentations made throughout the province and we're talking about an issue here that, if we didn't know before, we certainly learned during the course of the hearings is a very controversial area.

Again, I maintain that the best approach, if I was bent upon the ban in the way the government is, would be to do nothing but to keep the term that had been originally provided for, which is one year to adjust. But to reduce it to the end of this year, we may be looking at six months. I think it's unfair of the government to do that.

It doesn't allow time for those people who would be affected to comment on the shortened period. We were talking about the game here, the rules of the game where it was going to be until the first anniversary of the day it comes into force, which would have taken it, who knows, maybe till June 1995. I think it's just unfair, and the government shouldn't have moved this motion. It should have left it, at worst, the way it was.

**Mr Sterling:** I don't understand the government. This is like rubbing salt into the wound. Why are you doing



this? In the legislation now you're going to give the pharmacies a year to adjust from the date when this bill is proclaimed. Now you're going to give them, I don't know, seven or eight months, six months, whatever, whenever this legislation is proclaimed. I don't understand you. This is like saying to the pharmacies that are relying on the sale of tobacco to support their business, "We beat you down and now we're going to kick you."

Why are you doing this? What is the necessity? Once the public statement has been said that pharmacies are no longer going to sell tobacco, once you've done that, why not be more than reasonable in giving those pharmacies that have to readjust time to readjust? Instead, what you're saying here is, "We're going to get tougher and we're not only going to kick you, but we're going to kick you when you're down." This is craziness.

Why are you doing this? Maybe the parliamentary assistant would say. What's the necessity of this? Most people who appeared in front of this committee, even the people who proposed that pharmacies not sell tobacco, admitted that the effect of pharmacies not selling to the public was going to have none or near none in terms of effect on the consumption of tobacco in this province.

All you're doing here is acting like the big, tough government that doesn't care about the small business owner or the jobs that are related to this. This is a heck of a nice Christmas present for the people who are going to lose their jobs on December 31 because the revenue of that pharmacy has fallen off.

Why don't you carry these people at least through the winter? The nice part about a year from May or June, when this would be proclaimed, is it at least would carry those jobs that are going to be lost because of this loss of revenue until that time. I don't understand you. Why do you want to take it from a year to seven or eight months, Mr Parliamentary Assistant?

**Mr O'Connor:** I appreciate the opportunity to comment. We heard, as I said, from people as we travelled, for example, to Thunder Bay, from Tobacco-Free Thunder Bay. We heard from people like Dean's Pharmacy when we were in Sudbury, who drove all the way from North Bay, that this time should be reduced. He, as a pharmacist from Dean's Pharmacy, had said to us that we don't need a longer time, it should be shortened.

In fact the number of people who came forward to us and said that it should be only 90 days after royal assent has been received was a huge number of people. At the same time we heard from people, for example, around the vending machine issue that they needed some more time, for folks who were involved in that type of small business whose only product could be that tobacco product. When we saw the federal government went with a total ban on vending machines throughout most of the province, these types of considerations all need to come into play, so you'll note as we get into the debate a little bit further that we're moving to December 31 for them as well.

It's a clear date. It's something that they can work around while the legislation is working its way through the process to get to the Legislature for third reading debate. They'll have a date, they'll have something that's

there, it's not going to be a date that could be held out there and they don't really know what the date is. The date would be December 31 and they'll know. So for the people like the Ontario Public Health Association that came to the committee suggesting 90 days, we're saying no, that's a bit too short. I think that people have to have a day so that they've got something to plan towards.

**Mrs O'Neill:** I just take a bit of exception to Mr O'Connor's statement that huge numbers came before us suggesting that we shorten the time. I think my memory is pretty good and it's likely about six, if that, who came before us. I don't consider that a huge number.

But that being said, we're putting a date in a piece of legislation. We don't have the legislative agenda at the moment, and, if I remember very correctly, in December 1993, which is not that long ago, there were many bills that just didn't come to pass. We don't know whether this bill is going to be passed.

We have no idea how this government is ordering its business, but of course, it's nothing new because this government has not been the least bit hesitant to pass legislation that is retroactive. So perhaps that's what this date will eventually mean, that it will be retroactive. To have that kind of precedent that has been set and reset by this government, that we will set dates even if bills aren't proclaimed, in my mind is a very bad precedent and it's very bad government.

**1550**

**Mr O'Connor:** I certainly appreciate that, but I do believe that this is a priority I don't think just for the government but for the opposition members as well who have spent a considerable amount of time here. This is a priority. It's something that I think all committee members certainly will want to make sure gets on the agenda and that it gets passed. So I don't think that the date is too unreasonable given the numerous people who did make presentations to us suggesting that there be a shortened time frame, many of them suggesting a 90-day time frame.

**Mr Jim Wilson:** The parliamentary assistant, in defence of the motion, speaks of presenters who asked us to consider a shorter time frame than the one year from proclamation that was contained in the original bill. I don't have the transcripts in front of me, but it strikes me that, when you think of most of those pharmacists, a lot of those you're quoting had already stopped selling tobacco products in their stores, but they did so in the late 1980s, when we were absolutely in booming economic times. They did not have economic loss because they told us that they were able to bring in new products and adjust over a period of time.

You're in a recession, Mr Parliamentary Assistant, a very, very serious recession, and to shorten the adjustment time for these retailers is really adding insult to injury. It doesn't make any sense to us whatsoever. In fact, to me as Health critic, it plays into what former Deputy Minister of Health Michael Dexter used to say, and that is that there are too many pharmacies in the province.

With a shorter period here, you raise your likelihood of losing a few more pharmacies, driving them out of

business because they won't be able to adjust. I think we were told in very clear terms by some of the non-traditional pharmacies like A&P that they will close their pharmacies if it's a toss-up between the cigarette counter at the front and the pharmacy at the back of a store.

It just doesn't make any sense at all from a perspective that you must take into consideration and that the government isn't taking into consideration, and that's putting yourself in the shoes of these retailers; you're unilaterally telling them they can't sell a legal product. They need time to adjust. They need more time, not less time, during a downturn in our economy, during this very severe recession.

You don't have the right to bury your head in the sand and ignore the pleas of the people who came before us and made good commonsense arguments. These are people who are actually retailers, creating the jobs in our province. They know of what they speak.

Your government just totally ignores those pleas, as if business people don't know how to run business and you guys know how to run it better. Well, you don't, and the proof is that there are thousands and thousands of people being laid off in this province every day because you people don't know what you're doing.

Now in the name of health care you're going to lay off a few more people in the province, and you won't even take a reasonable approach to try and minimize the job-loss effect. It just defies any type of humanity, of humane treatment for the people of this province. It's downright disgusting, that's what it is.

**Mr O'Connor:** I guess this is where we get into a little bit of political rhetoric. If you want to talk about this recession, brought on by a government in Ottawa that knew exactly what it was like to do business and rammed through free trade and cost hundreds of thousands of jobs; if we see the Tory government in Ottawa that said we had to go with an extended period of time of high interest rates, of a very high dollar, artificially inflated, that it was really good for business; if that's the way that this goes about, I guess we've got a problem here.

The fact is, and you will recall, we had presentations come to this committee by pharmacists who had, as we were going into this Tory-created recession, made the decision to get out of tobacco sales. Now, as all the indicators are stating we are coming out of this recession, after listening to people suggesting that the time frame should be limited, I think it comes time where—as the college has said, it has been trying for years to get pharmacies to break themselves of the habit of selling tobacco products. Now the arguments have been made and now we have something before us. I guess this is, again, where we come up with these philosophical differences of opinion.

**Mrs Caplan:** I'm not going to engage in the rhetoric. I think a lot of very sensible points have been made, rhetoric aside. I am concerned about how important it is when drafting legislation that people who are affected by the legislation have some certainty and have time for adjustment.

It seems to me that the legislation, when it was tabled,

said there would be a period of time following proclamation. I prefer having a time line that follows proclamation or a time line which is established when the bill is tabled. If you're going to have a set date, then you do it when the bill is initially tabled and you can anticipate into the future a couple of years, which will allow time for the legislative process.

The concern I have is that I think it's very unfair to change the rules at the end of the process as far as the time is concerned. I think you would do better, both in the acceptance of the legislation and the implementation of the legislation, if you stayed with the original time line you have in the bill, simply because that was the expectation that was there. I think the person who spoke to this most eloquently was your own member Ms Haslam when she said, "You tell people when it's coming, and that's the time and the time line that they are required to adjust to."

I thought my colleague from Ottawa-Rideau, Mrs O'Neill, laid out the case extremely well, so I'm not going to get into all of the details that Mrs O'Neill has stated, but I do think there's an issue of fairness. If you tell people something's going to happen at a certain point in time when you table your legislation, that's a reasonable expectation. When at the end of the legislative process you come in, because some people came to the committee and said, "You could do this faster"—you might well have had a very different response as people came forward if they knew that your time line was December 1994. You didn't hear from anyone on that, because that wasn't in the legislation.

I think in the name of fairness that you should withdraw this amendment and go with your year from the date of proclamation, because I believe in the integrity of the legislative process. Time lines should be the ones that are established at the beginning of the legislative process. I very much object to retroactive legislation, but I think that in fairness to both the people who have come to the committee and those who will be affected by this legislation, you should go with what you initially announced when this legislation was tabled.

**Mr O'Connor:** I appreciate that opinion. The fact is that we also heard, for example, from vendors who sell this product through vending machines. When a similar piece of legislation was enacted in Ottawa by the federal Conservative government of the day, it put in a total ban from the day of proclamation of the vending machine element.

We heard from people who came to this committee suggesting that the time frame isn't fair because quite often that is the only product they have and we'll come to a point where we're going to put an amendment forward that will recognize that they have a hardship as well.

I think that by putting a consistent date, December 31, 1994, it responds to some of the presentations to the committee and I think it's a date that is reasonable. I appreciate hearing your views.

**Mr Jim Wilson:** I just simply want to say that it's a sad day in Ontario politics that when you go to defend those who might lose their jobs, when you point to



studies showing job losses, when you talk about the downsides of a piece of legislation, that somehow this is rhetorical.

I'd ask people to look in the dictionary as to what the word "rhetoric" means. To point out facts in a debate that were presented to us in good faith by the people of this province is not rhetoric, and I would ask members to keep that in mind when they're representing their constituents and the people of this province.

1600

**Mrs Caplan:** Just as a last comment, I think the parliamentary assistant has missed the point that I was trying to make. It seems to me, if I remember correctly, that the legislation that went through the federal House, from the day that it was tabled for first reading, said that it would become valid upon proclamation. They didn't change the date at the end of the process.

It seems to me that if you're going to do anything through the legislative process, you would extend the date in response to what you hear. But it is inherently unfair, after you've gone through a legislative process, to change the date by shortening it. The expectation that you raise at the time you announce your intention of legislation and table it for first reading I think establishes an expectation of what people rightly can expect the government is going to do.

It seems to me that if you're going to be sensitive to their need to have some certainty, then the time line is either established at first reading or, if you find that you're going to do anything, you extend it. It is tremendously unfair, and it's in the name of that fairness as well as acceptance of what you're doing that I'm suggesting the time lines should be those which were established at the time of first reading.

To point to another level of government or to point to somebody else and the way they've done things in defence of how you're doing it I think misses the point entirely. It really is looking at what's reasonable, what's fair and what's going to respond to the kind of expectation that you yourself have raised around the integrity of the legislative process.

**Mr O'Connor:** To respond quite directly to that, because this process happened about the same time as the federal process was taking place, we have to take a look at that. In that process that the federal government was going through around its tobacco control act, they had suggested that the date of implementation would be July 1. The Conservative government was convinced that would be a good time for proclamation, and so people knew that would be a reasonable sense.

But in the element of fairness, the Liberal government of the day decided it would move that forward quite a bit. I guess what isn't sure is when things can be proclaimed. The Liberal government proclaimed it much quicker, so for all those people with vending machines who were affected immediately instead of July 1 as they had thought would happen, there needs to be an element of fairness. I agree with you: There needs to be an element of fairness. I think December 31 is one way we can have that element of fairness you talk about.

**Mr Sterling:** I'm glad there's some recognition that the former federal Conservative government was acknowledged by the health community and by the people who are against tobacco as leaders in the world in terms of dealing with this issue. They talk about Jake Epp and they talk about some of the other federal Health ministers who took steps no other government in the world has in dealing with tobacco issues. They'll freely admit that to you, and I'm glad the parliamentary assistant is recognizing their leadership in that role.

The banning of the vending machines in the federal legislation isn't a banning of vending machines; it's a control of vending machines to certain kinds of premises. For the parliamentary assistant to compare this particular act with what the federal government had done is really not a fair comparison at all. One has nothing to do with the other.

In fact, the federal government has dealt with vending machines in a more reasonable fashion than we have here. They have said that where they are controlled, you can still have vending machines. What we heard from the vending machine owners here, at least what I was interpreting from their submission, Mr O'Connor, was that they would live within the federal legislation and would accept that as a reasonable restriction on their business. But the Ontario government has said, "We're going to put you out of business." That's what has really happened here.

I have a constructive suggestion for you, Mr O'Connor. If you want consistency, if consistency is your argument, let's give vending machine owners a year from proclamation, as you already have in this act. Let's go to the longer period rather than the shorter period, to give not only pharmacies but vending machine owners the ability to readjust, so they can sell their stock in other jurisdictions which still permit them.

If it's just a question of consistency, we're dealing with two bodies: first, pharmacies, of which there are not that many in this province, and we'll know what date this is proclaimed and there will be no problem with them recognizing it's either June 3 or May 28 or June 15; and the very small number of vending machine owners will also be well informed about this date. Your argument about who will know what date it is I don't think holds water, because we're dealing with a very small number of Ontarians in terms of knowing the date this will affect them.

Why don't you accept my constructive suggestion and keep both these dates so that the jobs in the pharmacies can be maintained and the jobs associated with the vending industry can be maintained as well?

I was really struck by the people who have their money in the vending machine industry. These are honest, hardworking, small business people. I don't like what they're doing. I don't like tobacco and I don't like the effects of tobacco, but they are taking a legal product and they are selling it through a legal means. We are saying to them: "No. That's the end of your business, mister. It doesn't matter if you've invested your life savings, mortgaged your house, to buy these machines. That's the end of your business."

I have more concern about them than I do the pharmacies, because the pharmacies have other matters to turn to. For the vending machine people, this is their livelihood. Your argument for bringing only the pharmacies to December 31 to give them time to readjust is not one that holds much water, and therefore I urge you to give both of these groups of people, who are going to have significant readjustments, a year from proclamation date.

**Mr O'Connor:** I really appreciate my colleague giving some constructive suggestions. In terms of the what he said about the federal act, I didn't say I thought it was a very courageous step forward. Their legislation dealing with prohibition of advertising, which I thought was good—and then the Jake Epp amendment allowed du Maurier to advertise the jazz festival. It's not cigarettes, but it looks like a cigarette package; it's the same colour.

I'm not saying the federal government's legislation was the best piece. I'm just saying you have to take a look at it. The federal Tory government had suggested that vending machine bans could take place immediately, but had talked so the community out there knew they meant, let's say, July 1. The Liberal government, after the election, decided to move that forward. They decided they were going to sell out to the Liberals in Quebec and drop the taxes, which forced us into an untenable situation that I don't think we need to get into, but I think that's a problem.

What we're talking about here is some reasonableness, and December 31 allows for a little reasonableness in this. For you to quote me and say that I thought the federal piece of legislation was the best piece of legislation—any time we can move forward on this product that every year prematurely kills 40,000 Canadians and 13,000 Ontarians, a step forward by any level of government is a good step. What we've done here is put in a sense of fairness and balance, and we've put in a date people can see. It's something that's written down. It's not “when-ever” or “maybe.” It's a date that's written down so the people have something they can plan towards.

1610

**The Vice-Chair:** You've heard Mr O'Connor's motion to amend subsection 4(3). All in favour? Opposed? The motion is carried.

Section 4, as amended.

**Mr Sterling:** No. Mr Chairman, I asked that we go through section 4 subsection by subsection, by number, and have recorded votes on this.

**The Vice-Chair:** There's a suggestion by Mr Sterling that the committee deal with section 4 subsection by subsection, with a recorded vote. Does the committee agree to that procedure? Agreed.

**Mrs O'Neill:** And Mr Chairman, as we go through this, please remind us of the areas that have been amended.

**The Vice-Chair:** Subsection 4(1): All in favour?

**Ayes**

Abel, Caplan, Carter, Frankford, Haslam, McGuinty, O'Connor, O'Neill (Ottawa-Rideau), Rizzo, Sterling, Wilson (Simcoe West).

**The Vice-Chair:** Opposed? None. That's carried.

In subsection (2) you want each of the paragraphs done, is that correct?

**Mr Jim Wilson:** Yes.

**The Vice-Chair:** The clerk is clear. I'm not.

All in favour of paragraph 4(2)1?

**Ayes**

Abel, Caplan, Carter, Frankford, Haslam, McGuinty, O'Connor, O'Neill (Ottawa-Rideau), Rizzo, Sterling, Wilson (Simcoe West).

**The Vice-Chair:** Opposed? None again. That's carried.

**Mr Sterling:** On a point of order, Mr Chairman: Could you read the subsections as we are voting on them so people who are watching understand what we're doing?

**The Vice-Chair:** Then we're to paragraph 4(2)2, “A private hospital as defined in the Private Hospitals Act.”

All in favour?

**Ayes**

Abel, Caplan, Carter, Frankford, Haslam, McGuinty, O'Connor, O'Neill (Ottawa-Rideau), Rizzo, Sterling, Wilson (Simcoe West).

**Mr Sterling:** Mr Chairman, I want to make certain it's understood that we're voting on sections that ban certain facilities from selling cigarettes, that we're naming those particular places where you can no longer sell cigarettes.

**The Vice-Chair:** In other words, “No persons shall sell tobacco in the following designated places.”

**Mr Sterling:** Yes. We voted for two where we've banned it, and we've agreed unanimously to ban that.

**The Vice-Chair:** Thank you. Paragraph 4(2)3, as amended, says, “A psychiatric facility as defined in the Mental Health Act, except, in the case of a facility that is designated under the Mental Hospitals Act, a part of the facility where the sale of tobacco is authorized by the regulations.”

All in favour?

**Ayes**

Abel, Caplan, Carter, Frankford, Haslam, O'Connor, O'Neill (Ottawa-Rideau), Rizzo.

**The Vice-Chair:** Opposed?

**Nays**

McGuinty, Sterling, Wilson (Simcoe West).

**The Vice-Chair:** Carried.

Paragraph 4(2)4, “A nursing home as defined in the Nursing Homes Act.”

All in favour?

**Ayes**

Abel, Caplan, Carter, Frankford, Haslam, McGuinty, O'Connor, O'Neill (Ottawa-Rideau), Rizzo.

**The Vice-Chair:** Opposed?

**Nays**

Sterling, Wilson (Simcoe West).

**The Vice-Chair:** Carried.



Paragraph 4(2)5, "A home for special care under the Homes for Special Care Act."

All in favour?

**Ayes**

Abel, Caplan, Carter, Frankford, Haslam, McGuinty, O'Connor, O'Neill (Ottawa-Rideau), Rizzo.

**The Vice-Chair:** Opposed?

**Nays**

Sterling, Wilson (Simcoe West).

**The Vice-Chair:** Motion carried.

Paragraph 4(2)6, "A charitable institution as defined in the Charitable Institutions Act."

All in favour?

**Ayes**

Abel, Caplan, Carter, Frankford, Haslam, McGuinty, O'Connor, O'Neill (Ottawa-Rideau), Rizzo.

**The Vice-Chair:** Opposed?

**Nays**

Sterling, Wilson (Simcoe West).

**The Vice-Chair:** Carried.

Paragraph 4(2)7, "A home as defined in the Homes for the Aged and Rest Homes Act."

All in favour?

**Ayes**

Abel, Carter, Frankford, Haslam, O'Connor, Rizzo.

**The Vice-Chair:** Opposed?

**Nays**

Caplan, O'Neill (Ottawa-Rideau), McGuinty, Sterling, Wilson (Simcoe West).

**The Vice-Chair:** Carried.

Paragraph 4(2)8, as amended, reads, "A pharmacy as defined in the Drug and Pharmacies Regulation Act."

All in favour?

**Ayes**

Abel, Caplan, Carter, Frankford, Haslam, O'Connor, O'Neill (Ottawa-Rideau), Rizzo, Sterling.

**The Vice-Chair:** Opposed?

**Nays**

McGuinty, Wilson (Simcoe West).

**The Vice-Chair:** Carried.

Paragraph 4(2)9, which has been amended to read, "An establishment where goods or services are sold or offered for sale to the public, if,

"i. a pharmacy as defined in the Drug and Pharmacies Regulation Act is located within the establishment, or

"ii. customers of such a pharmacy can pass into the establishment directly or by the use of a corridor or area used exclusively to connect the pharmacy with the establishment."

All in favour?

**Ayes**

Abel, Caplan, Carter, Frankford, Haslam, O'Connor, Rizzo, Sterling.

**The Vice-Chair:** Opposed?

**Nays**

McGuinty, O'Neill (Ottawa-Rideau) Wilson (Simcoe West).

**The Vice-Chair:** Carried.

Paragraph 10, which has been amended to read, "A place that belongs to a prescribed class." All in favour?

**Ayes**

Abel, Caplan, Carter, Frankford, Haslam, McGuinty, O'Connor, O'Neill (Ottawa-Rideau), Rizzo.

**The Vice-Chair:** Opposed?

**Nays**

Sterling, Wilson (Simcoe West).

**The Vice-Chair:** Carried.

**1620**

We move on to subsection 4(3), which has been amended to read, "Subsection (1) does not apply with respect to the designated places described in paragraphs 8 and 9 of subsection (2) until December 31, 1994." All in favour?

**Ayes**

Abel, Carter, Frankford, Haslam, O'Connor, Rizzo.

**Mrs Caplan:** I'm sorry. I did not want to support that amendment. Can you take the vote again? Is this not the change of date?

**The Vice-Chair:** Yes, it is.

**Mr Abel:** He didn't call your name.

**The Vice-Chair:** We haven't got there yet. Opposed?

**Nays**

Caplan, McGuinty, O'Neill (Ottawa-Rideau), Sterling, Wilson (Simcoe West).

**The Vice-Chair:** Carried.

Shall section 4, as amended, carry? All in favour?

**Ayes**

Abel, Caplan, Carter, Frankford, Haslam, McGuinty, O'Connor, O'Neill (Ottawa-Rideau), Rizzo, Sterling.

**The Vice-Chair:** Opposed?

**Nays**

Wilson (Simcoe West).

**The Vice-Chair:** Carried.

Now we have a PC motion to amend section 5.

**Mrs O'Neill:** On a point of order, Mr Chair: I don't know how in parliamentary procedure we can take that last vote when we voted on each, broke it out. How can we vote on it as amended? We're really nullifying several of our own votes.

**Mr Jim Wilson:** That's why I was consistent, Mr Chair.

**Mrs O'Neill:** I don't think that last vote should have been taken.

**The Vice-Chair:** Good point. Perhaps that's correct.

**Mr Sterling:** What does the clerk have to say about this? Do we vote or don't we need a vote?

**The Vice-Chair:** I think it's in order, personally. I realize my career is at stake.

**Mr Jim Wilson:** Ron, this isn't county council.

**The Vice-Chair:** We would certainly vote on the overall report regardless of the number of amendments that were voted on.

**Mr Sterling:** Is it necessary to have the vote? That's the question.

**The Vice-Chair:** I will seek professional advice, if I may. The answer is yes, the vote is required, but I understand your view.

**Mrs Caplan:** Does this mean you get a promotion to permanent Chair?

**The Vice-Chair:** Nothing is permanent, I have found.

**Mrs Caplan:** You got it: Nothing's permanent. That's the right answer.

**The Vice-Chair:** Can we rush on to section 5 at this point, a PC motion to amend section 5? Is there a motion in that regard?

**Mr Sterling:** Yes. I move that section 5 of the bill be struck out and the following substituted:

"Packaging requirements

"5. No person shall sell or offer to sell tobacco at retail or for subsequent sale at retail or distribute or offer to distribute it for that purpose unless the tobacco is contained in a package that,

"(a) bears no markings or words other than the marking or words required under federal legislation or under this act;

"(b) sets out the brand name of the tobacco in a standard script prescribed by regulation;

"(c) bears a health warning and other health information in accordance with the regulations;

"(d) is in a colour specified by regulation, and

"(e) complies with such other requirements as may be prescribed by regulation."

The present section 5 of the act ostensibly gives to the government the power to have tobacco packaged in some way in accordance with regulations. My concern about section 5 is that it holds out to those who want plain packaging, to the people who see that as detracting from the consumption of cigarettes—there's some valid argument that plain packaging leads to less consumption of tobacco because it makes it less attractive—the hope that this is going to take place.

My amendment really takes it the next step forward in that it specifies clearly to the tobacco industry what is about to happen to them in terms of packaging. I think it also would cut down the legal challenge the tobacco industry might have should it be faced with a regulation made by the provincial government at some time in the future.

I'm concerned that we have experienced by the tobacco industry in the past a tremendous resistance to legislators who want to take progressive steps to get rid of this deadly addiction we have in our society. You may remember back in the 1960s and 1970s when there was the health argument about whether tobacco did or did not cause a health detriment to our population. The tobacco lobby took great steps, threw great amounts of money at the whole notion of the mounting evidence which was

there for people to view. Finally, it caved in, as we saw the US Surgeon General in the early 1980s start to take a harder and harder stand on this.

If this government or a future government took the step of going to plain packaging strictly by regulation, my concern is that in front of a court the tobacco industry might say: "This really wasn't clear in the legislation that the intent of the legislators was to have plain packaging. It was there to regulate what kind of warnings may be on the package." In other words, it might be able to say smoke is detrimental to your health, and that might have to be in blue or green or yellow and it might have to be this big or that small.

If my amendment is accepted, it will be clear to the courts that the power given to the government to regulate in this area is clear, that the government of the day has the right to say, "This package shall be one colour regardless of brand, and you're allowed to have your name on the top or on the side or wherever, and it's to be this big and in this script, and this warning has to be on it which is twice as big as the name, that this is bad for your health," if that is the choice as the government of the day.

1630

That is the reason I've proposed this amendment. I want us to have plain packaging in Ontario. I want us to go the next step which I believe is necessary, because notwithstanding our previous leadership in this issue, I might say by a number of governments in Canada, we have not yet attacked this particular aspect of it as aggressively as I would have liked. Therefore I'm putting this amendment forward.

I might add that if you read section 23 of the act, this particular section comes into play when the government proclaims it. Again the government, as a cabinet, has the future ability to proclaim this particular section six months from today or can proclaim it five and a half years from today. That's what my understanding of the law is. In terms of readjustment by the tobacco industry to meet this kind of challenge, for them to be able to make their arguments, the government of the day will have that choice. I'm quite willing to give that choice to a New Democratic government or I'm quite willing to give that choice to a Liberal government or a Conservative government.

I do think it's time to move on to plain packaging, and I do not think the particular section contained in this bill is explicit enough. It may in fact lead to a long-drawn-out legal battle. We may have that regardless of the section we have in here because of the very, very high stakes involved in this issue, but I believe that by being more specific about what we're intending by this section, we will say to the courts, "Yes, we were contemplating plain packaging when this section was passed by the Ontario Legislature," and that's why I've put this amendment forward today.

**Mr O'Connor:** You've certainly given us very good arguments for the need for this area of the legislation to be amended, and I appreciate that. Much of what you said I must say I agree with.



The problem I have is that many parts of this refer to the regulations, and section 18 of the bill deals with the regulations portion of it. Perhaps it would be better if we have a chance to look at this in more detail, and maybe a more appropriate place for us to put this would be in section 18. I appreciate the arguments you've given us. Perhaps we can bring forward an amendment to section 18 that would be more appropriate because that's where we deal with the regulation on many of the packaging elements you have put forward in your amendment, and I appreciate that.

**Mr Sterling:** This amendment is fairly fresh and new, and perhaps the government caucus members need some time to digest this. You will note, Mr O'Connor, that there are also companion amendments to section 18 which marry with section 5 that I have proposed.

While I take your argument as some kind of notice in terms of trying to deal with it in that section, I don't think that would be appropriate. I would be quite willing to stand this down until perhaps tomorrow's hearings or some future time before we deal with section 5, if that's the desire of other members of this committee, so that Mr O'Connor can talk with the Minister of Health or other people in his government about the acceptability of the amendment.

**The Vice-Chair:** Mr Sterling has suggested that his motion to amend section 5 of the bill be stood down at this time. Is that agreeable to the committee?

**Mr O'Connor:** That's a very reasonable request, in light of the work he has done on this and given that we've only received this amendment today. I appreciate you giving us some time to take a look at all the amendments you've given us and see how this could fit into something later on in the bill.

**The Vice-Chair:** Is it agreed to stand down the amendment? Agreed.

**Mr Sterling:** Mr Chairman, would this be a good time to adjourn for the day? I would be amenable to that kind of motion. We have three days of sittings.

**Mrs Haslam:** Actually, we've got about 20 minutes.

**The Vice-Chair:** We have two more amendments on this section.

**Mrs Haslam:** Yes, but there's only section 6 left before everybody starts in on section 7. I'm wondering if we could finish up at least another one before we go.

**The Vice-Chair:** Is it agreed that we continue to approximately 5 o'clock? We will proceed.

The next motion is a government motion to amend clause 5(b).

**Mr O'Connor:** In light of the motion to stand down section 5, we can deal with that tomorrow, Mr Chair. Section 6 would probably be more appropriate for me to move at this point.

**Mrs Haslam:** Mr Chair, that was what I meant by my suggestion. I thought you were standing down all of section 5, not just Mr Sterling's amendment.

**The Vice-Chair:** Is it agreed that the government motion to amend clause 5(b) be stood down as well? Agreed.

**Mrs Haslam:** There's also a Liberal motion on section 5.

**Mr McGuinty:** I don't see why we couldn't deal with mine. It's not mutually exclusive from Mr Sterling's motion.

**Mrs Haslam:** Then I don't see any reason we can't go ahead and do the government motion too.

**The Vice-Chair:** Mr O'Connor has asked that his motion be stood down. What is your wish regarding the Liberal motion to amend section 5 at this time, Mr McGuinty?

**Mr McGuinty:** I prefer to deal with it now.

**Mr O'Connor:** That being the case, Mr Chair, I'd respectfully request that we then deal with the government motion.

**Mrs O'Neill:** It's our prerogative to change our minds.

**The Vice-Chair:** Mr McGuinty, would you move that we delay your motion?

**Mr McGuinty:** By all means.

**The Vice-Chair:** Mr O'Connor, would you proceed?

**Mr Sterling:** Just a matter of order here. If perchance the committee accepted my amendment, the government motion would be redundant. I presume the Liberal motion would be redundant as well.

**Mrs O'Neill:** No, it's got nothing to do with it. Have you read it, Mr Sterling?

**The Vice-Chair:** It's a different matter.

**Mr Sterling:** Yes, that is a different matter. I'm sorry.

**Mr Jim Wilson:** Let's not be stubborn. Let's just do the commonsense Liberal motion and forget about the government motion.

**The Vice-Chair:** Mr O'Connor, what would you like to do?

**Mr O'Connor:** I'll move clause 5(b), if that's the wish of the committee.

I move that clause 5(b) of the bill be amended by striking out "health" in the second line.

You'll note that the word "health" appears in the same sentence twice and doesn't need to be put in where it is. That's fairly clear.

**Mrs O'Neill:** I find this a very strange amendment on the part of the government. A health warning and health information are two very different things. A health warning indicates that we have some real difficulty with this product regarding health. Health information has to do with people who have certain conditions, usually, not conditions that everyone in the community has. Why would a government want to only confuse the issue? A warning is a health warning. This is a health issue. I can't believe you'd present this. I've listened, for four weeks, to members on the opposite side of this table talking about health issues, and now you want to take the word out? Holy, man.

**Mr O'Connor:** The importance here is that yes, this is a health issue and the health warning needs to be laid out quite clearly. We don't want to put ourselves into a position where we can only put health information on the

package. There may come a time when we'd like to put on, for example, ingredients. Somebody suggested that the pages of ingredients be put on there. If that isn't considered health information, we could probably say that it doesn't belong on there.

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**Mrs O'Neill:** We're not talking the same point at all.

**Mr O'Connor:** It's pretty clear that we've talked about the health issues, we've got the health warning element to be put on there, and we want to be able to have the ability—

**Mrs O'Neill:** But you're taking the word out.

**Mr O'Connor:** We want to have the ability to have other information contained on the package as we would require through regulation and not limit ourselves only to health.

**Mrs O'Neill:** Health should be emphasized in this bill over and over. Why you would want to remove such an important word from the key area that everybody said was key, the packaging—I can't believe it. I'm just incredulous. It just doesn't make any sense.

**Mr O'Connor:** Let's say, for example, that the government was to move forward with a suggestion that there be a 1-800-QUIT line on the packages, something that's going to help people who are addicted to this deadly habit quit. We could have the case argued that that isn't health information, but is just information.

The key here is not to take away from the health element of it. Clearly, this is a very important health issue and we could be denying people some very valuable health information if we were to take that out of there. This was suggested and the point was made quite clearly by the lung association from Middlesex. We heard from the Etobicoke board of health as well suggesting that there should be other information put on and we shouldn't limit ourselves and box ourselves in so tightly that, if we're going to offer cessation programs down the way—

**Mrs O'Neill:** But that's health information.

**Mr O'Connor:** —that we can't put that in there because we are limiting ourselves.

**Mrs O'Neill:** Well, your descriptions of things really are not the ones I've been used to.

**Mr O'Connor:** Mr Chair, to clarify this, because maybe the arguments I've put forward aren't clear enough, I would ask legal counsel if they could comment.

**Mr Williams:** Further to what the parliamentary assistant has said, when we went to legislative counsel to draft this section and discussed the various types of information we might want to put on packages, we were told that "health information" is very narrow in scope and that if we wanted information in addition to health information we'd be better off just using the word "information," which is much broader. Certainly there's no intention not to put health warnings on, but we want to make sure we could put other pieces of information that might not fit into the definition of health information on the package as well.

**Mr O'Connor:** We even heard from students, for

example, who suggested that smoking turns your teeth yellow and makes your breath smell. That wouldn't be a health warning.

**Mrs O'Neill:** I'm not sure.

**Mr Jim Wilson:** I'm not sure either. I don't agree with counsel at all. We got into this problem, Mr O'Connor, because you tried to throw the redundancy argument past us, that it was redundant to have "health" showing up twice in the same sentence. Obviously, we didn't buy that; Mrs O'Neill correctly didn't buy that and challenged you. Now we've got into all the other warnings you want to put on these packages. I'd like to see "Socialism kills" on the package, but I don't think—

*Interjection.*

**Mr Jim Wilson:** You guys have done some pretty crazy things. You've got the keys to the chauffeur-driven cars now.

*Interjections.*

**Mr Jim Wilson:** I'm quite serious. Look at your own labour laws and other things you've done. I would not give you—if we can do anything about it, and I guess our vote is the only way to do anything about it in this committee—the licence to expand beyond health warnings. I think the redundancy was there intentionally in the first drafting of the bill and the word "health" should remain. You've got a hidden agenda on this. I don't trust your government at all, to write you a blank cheque to put whatever you want on cigarette packages. You stick to "health." That's the reason you're driving the pharmacies out, in the name of health, and you stick to it consistently throughout this bill.

I don't agree with counsel who says you can't somehow convince somebody that a 1-800 health line is not a health matter. Where there's a will there's a way, and you can get the warnings you want on these packages under the definition of health. After all, the World Health Organization defines health very broadly, in fact in economic terms, that the best thing you can do for your country and your province is to have a strong export market and a strong economy. That is the definition of health that is used in the world today. It encompasses just about everything you've mentioned, Mr O'Connor, and I don't want you venturing outside that very broad definition of health.

**Mr O'Connor:** Again, there are some things we disagree about, for example, when we talk about Mr Jake Epp's amendment to the Tobacco Products Control Act that said a promotion isn't advertising. There are going to be times we disagree.

The key here is that if somebody is going to challenge us on whether we can put on a 1-800 line, as an example—I know there are other governments that would like to have things challenged and maybe make things redundant. We're trying to make this as encompassing as we can so we can put in things that are going to save people's lives.

**Mrs Haslam:** I thought perhaps we were taking out the aspect of warning. My concern would be around a challenge to what exactly health information was, if we leave it in; if there was something we wanted to put on



and they said, "That hasn't been proved to be a health effect of smoking." Let's say we came across something we wanted to put on that said, "Smoking affects the foetus." Would they make us prove that in a strictly health way? But my concern was something else—

*Interjections.*

**Mrs Haslam:** Gee, I love these cross-table conversations. They're just wonderful.

**The Vice-Chair:** Ms Haslam has the floor.

**Mrs Haslam:** My concern would be that type of information. I would like clarification again about the type of information you're talking about. To my way of thinking, it must be about smoking, it must be about the health aspects of smoking. What were the concerns raised by the lawyers drafting this?

**Mr Williams:** I can't answer what types of things would be on the package. The program area could better answer that. I can't speak for the present legislative counsel, because she's not the person I spoke to, but when we approached legislative counsel about other kinds of information that I wouldn't have called strictly health information, we were told that if we wanted to pass a regulation that would prescribe forms of information other than what you'd call health information, that wouldn't be broad enough. I don't know if legislative counsel's got any comment. It would be helpful if either the parliamentary assistant or Brenda could outline some of the things we were thinking of putting on a package.

**Mrs Haslam:** I would like to hear some of those things from legislative counsel. Legislative counsel had her light on; that's why I was watching her.

**Ms Filion:** The problem that was raised by counsel—I wasn't part of those discussions at the time, so I can only assume that the question was how we could avoid possible litigation surrounding the authority to make regulations in this area. I would assume the advice would have been at that time to put the language as broadly as possible, that if you remove the word "health" from that provision it would give as wide-sweeping regulation-making powers as possible.

**Mrs Haslam:** That they could fight over every type of warning we wanted to put on, including the contents of cigarettes, being not a health warning.

**Ms Filion:** An argument could be raised, yes.

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**Mr McGuinty:** One of the reasons my party has raised this is because if you look at the next government motion, it attempts to do the same thing. It adds "and other information" to the kinds of information that can be included on the signs that are to be posted in stores.

That's why it created a concern. It does give the impression that there's a hidden agenda here and that there's something that goes beyond health. If it's not related to health, I don't want it on the package, period. There's such a broad definition that could be attributable to "health," and I'm just very concerned about going beyond that which is necessary here. We're going after cigarette packaging because it's a health issue, period. I don't want to hear about anything else because I'm only concerned about the health aspect, and if it's not related

to health I don't want it on there. That's why I don't see any reason to remove that qualifying word, which is very important, "health."

**Mr O'Connor:** If I can try to put in another practical piece of information, we heard from many people about ETS, for example, and we could come to arguments about whether ETS is a health issue. We on this committee have heard many very good arguments about that, for example, but that could be considered by some people as "other information." The committee members heard it was a health issue, but the industry could take exception and argue that that is not health information, that it's other information. In the tobacco industry, a great deal of denial takes place about whether its product will cause cancer, cause premature death.

I would hate to see us stranglehold ourselves by not allowing ourselves the ability to include something on ETS, for example, or something else, as medical evidence comes forward that may point out information, but maybe not pointed directly at health, and then could be argued through the court process. What we want to do here is put out the messaging as clearly as we can, and we may tie ourselves just a bit too tightly if we deal with just the health warnings.

**Mrs O'Neill:** It has been said earlier today in this room that legislation is living. It's about living people and it's going to affect lives. We're talking about something that may happen way off in the future.

There is so much data at the moment that supports connection, whether it be through secondhand smoke or smoking itself or the effect on the foetus, that is so relevant, and is available right in this library and that our research has brought forward to us on our request from time to time. We have all kinds of evidence that smoking is a health-related matter.

If we are considering smoking in any other light, if we're trying to change freedom of choice, if we're trying to interfere in either the retailing or manufacturing parts of the tobacco and cigarettes issue, the government should say that, but it hasn't said that. They're always talking, whether it's about pharmacies or whether it's about long-term care facilities: "It's a health issue. It's a health issue." I have heard that, I'm positive, it's a thousand times in Hansard.

Now, all of a sudden, there's something else that maybe some day in the year 2054 is going to change things, and there's going to be something beyond health that we want to put on these packages. Or maybe they know right today there's something they want to put on packages that isn't health. Maybe it's something about behaviour modification, but even behaviour modification can be sometimes stated as a health measure.

To be told by legislative counsel that they were trying to avoid litigation in this bill—and that's what I heard, that that's the purpose of changing this—and then to be told by the parliamentary assistant that the word "health" appears twice in one sentence—that's not extraordinary, you know. I taught grammar at one time. I find the arguments preposterous, and I'm asking for a recorded vote on this amendment.

**Mrs Haslam:** As it is 5 o'clock and originally we had discussed setting aside all of section 5, could we do that now and return to this next day, start on section 5 at that time?

**Mrs O'Neill:** The parliamentary assistant said he wanted to get it done.

**Mrs Haslam:** I wanted to get as much done as possible, that we didn't knock off 20 minutes early today and then—

**Mrs O'Neill:** You want these arguments all over again tomorrow.

**Mrs Haslam:** We don't have time to address all the pieces, all the things in the—

**Mr Jim Wilson:** I agree. Agreed?

**Mrs Haslam:** Well, that's fine. I certainly will agree with you once in a while and cut you off in the middle of a sentence, Mr Wilson, because we sit over here time and time again and let you ramble on.

**The Vice-Chair:** Ms Haslam, complete your sentence.

**Mrs Haslam:** No. I've said my piece, thank you very much. Ask Mr Wilson to complete it for me. He knows what I'm going to say.

**Mr O'Connor:** To point to another example of a warning that could be put on there that may not be construed as a health warning, say it's that increased smoking would reduce your cardiovascular endurance. People could say that isn't a health warning, although maybe it would be in medical terms. Do we limit ourselves? My point is that we don't want to limit ourselves and hamstringing ourselves to only issues that are health warnings. It could be argued by the tobacco industry that a 1-800 line, for example, isn't a health warning, isn't health information, that it's information that could lead to better health and might lead to longer life for many people, but maybe it isn't health. Why put ourselves in a situation where we end up with something struck down through the courts later down the road?

**Mr Jim Wilson:** Because you have to limit yourself. Your bias is to extend everything so that Big Brother can do absolutely everything you want in all the legislation. You already have a history of three years of asking for

more regulatory authority than any other government in history in this province, and now you're doing it again. We try every once in a while as opposition members to get you to think about limiting yourselves to what you tell us is the intent of the act, to what you tell us is the reason you want to drive pharmacies out of business: for health reasons. You just can't have it one way in one part of the act and not be consistent throughout the act. You have to limit yourself.

And if you have a good health case for putting a health warning on, you're not going to have any problem under this act. You will have a problem if you start venturing in to put warnings that have nothing to do with the health of people as connected to cigarettes.

I think you should think about it and we should come back tomorrow. I agree with Ms Haslam that it would be a good idea to think about it. You're listening to the drafting people, and the drafting people aren't in our shoes; they're lawyers. They sit there and say, "If you really don't want to get in trouble in the year 2025, leave it absolutely open." That's a piece of advice you're given. You should take that advice, mull it over and say: "What's best? What's the intent of this act?" The intent of this act is to narrow in on health care issues.

**Mr McGuinty:** I'm ready to vote now on this one, Mr Chair. I'd be delighted to be able to deal with it.

**The Vice-Chair:** Any other speakers on this matter? If not, there was a motion moved by Mr O'Connor to amend clause 5(b). All in favour of that motion?

**Ayes**

Abel, Carter, Frankford, Haslam, O'Connor, Rizzo.

**The Vice-Chair:** Opposed?

**Nays**

McGuinty, O'Neill (Ottawa-Rideau), Sterling, Wilson (Simcoe West).

**The Vice-Chair:** Carried.

There was a Liberal amendment to the same clause, which we will deal with tomorrow. Thank you for your attendance and attention. It's been very exciting.

The committee adjourned at 1659.



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\*Rizzo, Tony (Oakwood ND)

\*Wilson, Jim (Simcoe West/-Ouest PC)

*\*In attendance / présents*

### **Substitutions present / Membres remplaçants présents:**

Abel, Donald (Wentworth North/-Nord ND) for Mr Martin

Caplan, Elinor (Oriole L) for Mr Beer

Haslam, Karen (Perth ND) for Mr Hope

Frankford, Robert (Scarborough East/-Est ND) for Mr Owens

Sterling, Norman W. (Carleton PC) for Mrs Cunningham

### **Also taking part / Autres participants et participantes:**

Ministry of Health:

Mitchell, Brenda, manager, tobacco strategy unit

O'Connor, Larry, parliamentary assistant to the minister

Williams, Frank, legal counsel

**Clerk / Greffier:** Arnott, Doug

**Staff / Personnel:** Filion, Sibylle, legislative counsel

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## Legislative Assembly of Ontario

Third Session, 35th Parliament

## Assemblée législative de l'Ontario

Troisième session, 35<sup>e</sup> législature

# Official Report of Debates (Hansard)

Tuesday 8 March 1994

# Journal des débats (Hansard)

Mardi 8 mars 1994

Standing committee on  
social development

Comité permanent des  
affaires sociales

Tobacco Control Act, 1993

Loi de 1993 sur la réglementation  
de l'usage du tabac



Chair: Charles Beer  
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## LEGISLATIVE ASSEMBLY OF ONTARIO

## ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON  
SOCIAL DEVELOPMENTCOMITÉ PERMANENT DES  
AFFAIRES SOCIALES

Tuesday 8 March 1994

Mardi 8 mars 1994

The committee met at 1006 in room 151.

TOBACCO CONTROL ACT, 1993

LOI DE 1993 SUR LA RÉGLEMENTATION  
DE L'USAGE DU TABAC

Consideration of Bill 119, An Act to prevent the Provision of Tobacco to Young Persons and to Regulate its Sale and Use by Others / Projet de loi 119, Loi visant à empêcher la fourniture de tabac aux jeunes et à en réglementer la vente et l'usage par les autres.

**The Vice-Chair (Mr Ron Eddy):** Good morning, ladies and gentlemen. The standing committee on social development, dealing with Bill 119, An Act to prevent the Provision of Tobacco to Young Persons and to Regulate its Sale and Use by Others, is now in session. We were dealing with section 5, and the next amendment is a motion proposed by the Liberals.

**Interjection:** I think Norm was first.

**The Vice-Chair:** We had stood the PC amendment down until today. I understand it will come up later. Is that right?

**Mr Norman W. Sterling (Carleton):** I thought we would deal with it now.

**The Vice-Chair:** Deal with it now? Fine. Mr Sterling.

**Mr Sterling:** For those who might be following the proceedings but weren't watching yesterday, section 5 of the bill, as it's now written, says:

"No person shall sell or offer to sell tobacco at retail or for subsequent sale at retail or distribute or offer to distribute it for that purpose unless,

"(a) the tobacco is packaged in accordance with the regulations; and

"(b) the package bears or contains a health warning and other health information in accordance with the regulations."

My concern over the section came from reading the explanatory notes as well. Section 5 in the explanatory note says:

"Tobacco sold to the consumer or retailer must be packaged in accordance with the regulations. The package is to bear or contain a health warning and other health information."

My amendment clearly points towards the fact that the Legislature is contemplating plain packaging. My concern over the existing section is that it is not clear enough, and the explanatory notes emphasize the fact that it is not clear enough.

My amendment says that no person shall sell or offer tobacco—and I have put forward formally the amendment

so I believe I can paraphrase at this time—unless the tobacco is contained in a package that (a) bears no marking or words other than the marking or words under federal legislation or this act, in other words, you can control what the words are; (b) sets out the brand name of the tobacco in a standard script, so you can control even the type of printing that is on the cigarette package; (c) bears a health warning or other health information in accordance with the regulations; (d) is in a colour specified by regulation, in other words, it could all be of one uniform colour. The last one, (e), is to provide the government with any other regulatory requirements necessary to deal with packaging.

My amendment, I believe, clearly sets out that we are, under Bill 119, if it's amended this way, contemplating plain packaging for cigarettes in Ontario. In speaking to the motion, in addition to that, there are some other benefits we should talk about.

Number one is, I believe, that plain packaging will in fact have some bearing on consumption of cigarettes, particularly for young people. I think young people are attracted by the colours, the logos, the attractiveness of the overall package when purchasing this product.

Second, I think there is another benefit which will exist because we will be the first jurisdiction in Canada and I believe the first jurisdiction in perhaps all of the world—I'm not aware of any other jurisdiction which requires plain packaging. We will be leaders in that regard if we take this step.

As long as we continue to be the only jurisdiction that does have plain packaging we will have the added benefit of being able to distinguish clearly between cigarettes which are legally sold in this province and those that are smuggled into this province and sold illegally. There's a twofold benefit here that while smuggling has dropped appreciably since the federal Liberal government led the way in dropping tobacco taxes, the future in terms of dealing with the smuggling problem, the enforcement against people who smuggle cigarettes, would be much easier if in fact we had plain packaging. In fact, if we went to plain packaging and other jurisdictions chose to follow the lead of Ontario, they of course could choose another colour of package in order to distinguish their cigarettes from another jurisdiction.

One of the things we should note is that, I think in fairness to people who are involved in this business, although I'm not overly empathetic to their position because of the product they're selling, this section, as you know, can be proclaimed under section 23 of this act at any time the government of the day chooses so to



proclaim this section. It also would be subject, of course, to regulation that would be made by the government, so I would suspect that any government would act responsibly in implementing this legislation in order to give those who produce the product a fair amount of time to readjust to the new regulations that would be coming out so there would be some kind of fair notice.

By putting this in legislation rather than leaving it totally to the regulatory powers of the government, it cuts off from the tobacco industry, who have exhibited in the past a great propensity towards litigation when a government challenges them head on—it puts them in a negative position in going to court and saying, “The Legislature really didn’t contemplate under this section 5 that what we were talking about here was plain packaging.” I believe it could be argued, perhaps successfully, that in section 5 as written the government’s intent or the legislative intent was to put larger health warnings on it, different health information on it and that kind of thing.

I just don’t want to, number one, invite that kind of litigation, although we will probably be faced with that kind of litigation in spite of whatever we might pass here. But number two is I think by adopting this amendment we are going to set a tremendous example to the people in Canada and North America to follow this lead towards plain packaging, and hopefully it will lead to a lot less consumption of this deadly product.

I look forward to hearing comments of the other parties, the members of this committee, and I’m quite willing to amend various parts of it to make it stronger, to make it better, to make it clearer, whatever is necessary in order to do that.

**Mrs Elinor Caplan (Orléans):** I’d like to begin my comments by saying that I’m very supportive of a national plain package initiative and I believe that’s the way we should be going on this. While I listened very carefully and I know Mr Sterling’s arguments are well thought through, it seems to me that on this issue, as on others on occasion which we would like to see Ontario move ahead of its neighbours and in his words “show leadership,” in fact that just doesn’t make common sense.

You can’t build a wall around Ontario. The success of what Ontario is able to do is affected by what is going to happen in the province of Quebec and the province of Manitoba and the rest of this country, where we have free and open borders and I hope we always will.

We have a border with our neighbours to the south, and we know that, while on occasion it leaks like a sieve, it does have all of the enforcement measures of both customs services as well as those kinds of controls on immigration.

I think the intent of this amendment is one which all parties can support and I think we will see this one day, whether it will be exactly in this form or slightly different. Whether it will be enshrined in legislation or done by regulation remains to be seen, and I hope we will see it sooner as opposed to later.

I know that the provincial minister, Mrs Grier, has agreed to speak to and negotiate a national plain package strategy with all of the other provincial governments, and

hopefully the federal government will also support this kind of initiative with a national as well as a federal cooperative measure.

Having said that, it seems to me that to proceed unilaterally in Ontario runs at cross purposes. I listened very carefully. When he suggested that this would allow us to identify those cigarettes which were illegal in Ontario because of the package, to me it sent up alarm bells. It sent up alarm bells because I’ve been trying to explain to people the kind of Ontario that I want to live in, and I believe that we should have optimum freedom for the individual.

The thought that somebody might buy a package of cigarettes in another province or outside the country and bring them into Ontario quite legally—whether it’s from another province or across the border they’re here quite legally—but because of Ontario’s plain package provision would now be engaged in criminal activity because of the cigarette package in their pocket to me is ludicrous and ridiculous. I’m pleased to see that Mr Sterling is laughing as well.

**Mr Sterling:** I’m laughing at your arguments.

**Mrs Caplan:** I think that we have to attach a healthy dose of common sense to this kind of provision as we move forward to see the kind of tobacco strategy that will achieve the objectives we all share, which is particularly to see young people not start and older adults who have already started be assisted in quitting.

**1020**

I don’t think plain packaging would in any way be an initiative that Ontario could undertake on its own unilaterally with any success. It’s because of that that I hope we will see an interprovincial and a national initiative fairly quickly which will achieve those goals and objectives, and it’s because of that that I really think this is premature at this time, although I know there is a lot of support within my own caucus. I personally am very supportive of a plain packaging initiative, but I do think it’s the sort of thing we have to do in concert with our partners in Confederation.

**Mr Larry O’Connor (Durham-York):** The member for Orléans has been a very able spokesperson at this point for some of what is happening with the current government. In fact the Minister of Health has stated that she is going to work together with all the provinces to deal with the packaging issue.

I guess we could talk about attitudes and responsibility and I think this is a responsible way so we don’t have a patchwork-type process take place similar to what has happened with the smuggling issue. We’ve seen a patchwork approach by the government in Ottawa that didn’t deal with each jurisdiction and try to help out. I think a responsible national process here is necessary.

Mr Sterling, if we were to have a vote on intention here, I think your intention would be upheld. I think committee members around the table want to see the direction move towards plain packaging. I’m not sure whether or not by limiting it through your amendment here we could cover all the elements that would be necessary.

I could use an example. We’ve seen those lighters—

they call them Bic lighters—and then they sell sleeves for them. The next thing you know, when we talk about packaging in the tobacco industry, we could have a sleeve come off. What you had was plain packaging, and they can justifiably say, “When we sold it, it was in a plain package,” and out it comes and it’s not a plain package any more. There are many ways that I think, for all the intent that you want to put in there, it could fall apart.

I guess one of the difficulties in fact where this province is trying to consult with some of the people out there, for example, the Ontario Campaign for Action on Tobacco, our department has been talking to some of its lawyers to try to make sure we cover all bases so we don’t do this in isolation so that if it comes to the point where you say we could end up in litigation, and I agree that’s a huge potential, we have in place the very clear evidence that for all the social science reasons you spelled out that consumption could be affected by plain packaging—I think through these committee hearings we all may agree with you at this point, but that may not be something we can get the courts to agree with. I think there needs to be some time allowed to develop that type of information. It needs to take place.

I guess what I’d like to do for some clarification maybe is ask our legal counsel here, Frank Williams, from the ministry. We’ll give him a chance to have a career-enhancing statement here.

**Mrs Caplan:** Career-enhancing means you agree with the parliamentary assistant; career-limiting means you don’t agree with the parliamentary assistant. Is that your definition?

**Mr O’Connor:** If you could take a look at clause 5(a) as it’s written, does that not have the ability to allow us to move with the intention Mr Sterling has while maybe not limiting us to just what he’s got covered?

**Mr Frank Williams:** A simple answer: yes.

**Mr O’Connor:** There’s the answer.

**Mrs Yvonne O’Neill (Ottawa-Rideau):** I wouldn’t give that answer if I was depending on my career enhancement. There must be something more complicated.

**Mr O’Connor:** I guess, for legal advice, we certainly got it short.

**The Vice-Chair:** Concise.

**Mrs Karen Haslam (Perth):** That’s the shortest legal answer I think any of us have ever heard.

**Mrs Caplan:** I think he was thoroughly intimidated by career-enhancing and career-limiting.

**The Vice-Chair:** Mr O’Connor, continue, please.

**Mr O’Connor:** The point here is that I think we could end up limiting ourselves. For all the good intentions Mr Sterling has pointed out, and I think we’ve got almost unanimous support for your intention here, we could limit ourselves. The intention of what we’d like to do here and to have ourselves limited in this, if we ended up in a litigation situation, if we didn’t have adequate social science evidence that would allow us to take this through the courts and come up with a successful conclusion, I think that we as legislators would be on the

losing end of that as well as all those people who have come before us advocating for plain packaging.

**Mr Sterling:** Perhaps I could ask legal counsel a question as well. Do you see my amendment in any way limiting the ability of the government to bring in plain packaging?

**Mr Williams:** The problem, when you start listing all the different elements that you want to regulate with respect to a package, is that if you leave something out and you want to come along later on and add something that’s not on that list, the courts tend to take the view that if you start listing, the specific overrides the general, to use sort of the common legal phrase.

What happens then is the court looks at the very narrow list that you have set out in the legislation and it says, “You’ve only covered size and you’ve only covered colour. You didn’t cover lettering,” or you didn’t cover this. My fear is that if we start listing, we’re liable to leave something out. I’d rather be general, which covers, in my view, everything. That gives you the ability to regulate any aspect of packaging that you want to regulate at any time you want to do it.

**Mr Sterling:** That argument, in fairness to legal counsel, goes so far, but you also have to express the intent of the Legislature as to what you’re getting at in order to prevent the legislation from being attacked in terms of the extent of where those regulations go. So it’s a fine balance between how far you go in terms of specifying what you’re up to. You can’t say in an act, for instance, you can regulate whatever you want to regulate, to take the point to the ridiculous.

**Mr Williams:** I agree with you, there’s a fine balance and I guess, given my druthers, I’d rather do it in a general way than start limiting it. I can’t give you a definitive answer to say yes, the courts will go one way or the other. I can’t prognosticate what the courts would determine, I can only give you my best judgement as to how I think I would do it and I’ve given you that.

**Mr Jim Wilson (Simcoe West):** With respect to this latter point, I don’t understand why, if an amendment is required to Mr Sterling’s amendment, we couldn’t simply make a statement that this is the minimum requirement with respect to plain packaging. Then you’re not limiting yourselves, you’re simply setting a floor rather than a ceiling. I think Mr Sterling’s point is well taken, that both for the public and for the courts, the government’s intention with respect to section 5 should be spelled out. We have an obligation to do that.

I’m stunned, actually, with respect to the comments from Mrs Caplan and Mr O’Connor. I wonder who actually now is in the pockets of the tobacco lobbyists. We saw the federal government cave in on the issue of taxes. We’re now seeing Mr O’Connor make a number of what really are false arguments with respect to this issue that I’m sure in the past his party would not have made and did not make.

To deal with the comments made from the Liberal Party and a similar comment shared by Mr O’Connor about you can’t build a wall around Ontario, it seems to me to be an argument of convenience that you’ve both



pulled out of the bag of tricks this morning, because if you look at the rest of this legislation with respect to having the age—the minimum age is at 19 in this legislation and in the new federal act is 18. The federal act does not ban pharmacies; only Ontario at this point is banning pharmacies. We also have the total ban in this act on vending machines, and the federal act does not have a total ban on the sale of tobacco products through vending machines.

I think it's quite clear that this act in several other areas goes beyond what is the national norm now and therefore it is a false argument and an argument of convenience to simply say you can't build a wall around Ontario with respect to plain packaging.

Mr O'Connor talked about social evidence and I think if there's one thing that I've learned through this process, it's that one of the very best things you could do is introduce plain packaging. I think the evidence is very compelling indeed in supporting the objective of this bill, which is to stop young people from starting to smoke.

#### 1030

Both in committee and in meetings with groups we have been presented with very strong evidence suggesting that if you can take the attractiveness out of the package, that would have a greater effect in fact, in my opinion and from the evidence I've seen, than the measures currently contemplated in Bill 119 with respect to age or removing it from pharmacies or vending machines. I think this would be finally some real piece of legislation in front of us that we shouldn't miss the opportunity to pass this morning.

I've been of the rather sceptical view with respect to Bill 119, since I read in the early newspaper reportings and media reportings about this bill, that this bill would bring in plain packaging. The government, at the time of those reportings, and the minister's press conference did nothing to quell those expectations from the public, so you have an expectation out there that plain packaging is coming with this legislation. You also have a number of other expectations out there that are not met with the bill in its current form.

You got a lot of praise from the public as leaders. Now Mr Sterling is giving you the opportunity and all members the opportunity to be true leaders on this issue. He's thought out the arguments with respect to proclamation of this section. You don't have to proclaim it at the same time as all other sections of the bill; you can work with the people who produce these tobacco products, but none the less your intention is extremely clear and would send a very strong signal to the rest of Canada, and indeed the world, that Ontario is prepared to move.

I think you'll find that other jurisdictions, rather than buck the trend, will thank you for your lead on this issue and will in fact follow suit. Ontario is the largest consumer area in the province and, if it made a move like this, I think you would find, like the tax issue, other provinces have to follow suit.

I don't see any downsides to this. In my own riding where a number of people smoke, including many people who are near and dear to me, like my parents, they're

going to continue to smoke regardless of what the package looks like. For goodness' sake, many of them were smoking illegal cigarettes that had kind of funny packages anyway prior to the taxes being lowered. That's not the point. The point is that the evidence clearly shows that young people will not be attracted to this product if you bring in plain packaging or generic packaging.

I don't buy any of the arguments that the other two parties have conjured up. We've heard them all before. We're giving you an opportunity to show leadership. If we do this unanimously, then we will face what criticism might come from the industry, and we'll face it together.

We're giving you that opportunity and we're prepared to do that with you and to work with the government on this issue because we think it finally puts some teeth into this act. That has been our complaint all the way along. You've been quick to do other things that I don't really agree with, and particularly the pharmacy issue, because I don't think it will meet the objectives of the goal. I think it's more symbolic.

Here we're giving you an opportunity to do something that isn't symbolic. The evidence is compelling. I think any court that sees that evidence that I and Mr Sterling have seen with respect to this issue would side with the Legislature.

I don't buy a scapegoat this morning, asking legal counsel to get you out of some excuse, Mr O'Connor. Where there's a will, there's a way. Any arguments I've heard so far this morning indicate that no Legislature would ever be able to do this. That's crazy. If you want to take a few minutes and suggest some amendments or a partial redrafting, that's fine, but you can't have your cake and eat it too on this issue.

You've got a public expectation out there that you are indeed taking a leadership role on the issue of stopping young people from taking up the habit of smoking. Yet if you don't pass this, I think you fail that test.

**Mr Dalton McGuinty (Ottawa South):** I want to speak in support of this amendment. Here once again we're focused on what I believe should be the focus of the bill. We're talking about making it harder for the young people in the province of Ontario to start smoking in the first place. We're not talking about banning sales in any particular location. We're not talking about making it harder for old people to get their cigarettes or for the psychiatrically ill to get their cigarettes or whatever. We're back to basics. We're talking about kids.

I think if there's one thing that we all learned during the course of the hearings, it's that kids are attracted to packaging. As one woman put it in Sudbury, a cigarette package is an accessory, much in the same way as earrings might be, a belt, the latest jeans. It's something you have because you want to be seen with it. I think if we really want to put a dent in the number of kids who are starting to smoke, this type of provision goes hand in hand with and is complementary to a law which says you can't start smoking when you're young.

I recall doing reading for my own private member's bill which even showed that there was a study done in the United States where they offered smokers of Marl-

boro plain packages holding Marlboro cigarettes at a discount, or paying full price for the Marlboro cigarettes. The great majority of those smokers preferred the traditional package because they wanted to be seen with the darn package. So let's not underestimate the power of the packaging as a draw not only to smokers but, more important in our case, to young people starting to smoke in the first place.

The other thing I like about this amendment is that it's made in great part because it's anticipating legal consequences: If we had to move on this, how would the other side react? It's interesting to put this in distinction with the pharmacy issue, because there the government has obtained a legal opinion, but it's not prepared to share that with us.

The argument was made by my colleague and by the parliamentary assistant about how it would be better to move on a national scale to address this problem, and I agree. Ideally, that would certainly be the best way to go, but there are some issues, I think, which warrant our superseding that general principle. I feel very strongly about young people starting to smoke and the impact of the packaging in that dilemma.

I think there are times when a particular jurisdiction, whether it's a municipality or a province, can actually show leadership with respect to particular issues. It can free the logjam, so to speak. A number of the provinces, based on my research, I know would like to move ahead on this, are waiting for action at the federal level, would like to move out on their own, and they just don't have the wherewithal to do so.

Nova Scotia, for instance, was the first to come up with the new age limit for young smokers. That's something obviously that they could operate within their own particular jurisdiction, but again they showed leadership in that regard, and I expect we'll be seeing other provinces doing the same kind of thing right across the board shortly.

With respect to this amendment constituting a limit, legal counsel tells us it would constitute a limit. I think clause (e) of Mr Sterling's amendment leaves it open in that it says that the packaging requirements must comply with such other requirements as may be prescribed by regulation. I think that quite clearly leaves it open in terms of the kinds of other regulations you might want to put in place. It leaves it open-ended; that's the long and the short of it.

I don't see how Mr Sterling's section 5 and the government's section 5 as found in Bill 119 are mutually exclusive. If anything, Mr Sterling's is merely more expansive. I don't see it being restrictive in any way. You might make the argument that it's all there in the existing section 5 anyway, but given that we've had an opportunity to develop a good understanding of how strenuous an objection would be raised by tobacco manufacturers in this country, I think it's probably a safe means by which to ensure that we're laying down the necessary groundwork that will stand us in good stead before a court.

1040

**Mr O'Connor:** I appreciate the opportunity to address

this again. The important thing here is that the intention of the committee members is to support the intention that Mr Sterling has brought forward in this motion. I don't think there is anyone here who is comfortable, and I know the minister isn't comfortable, in waiting for the federal government to deal with it by itself. What we're saying, though, is it needs to be done in a national way, and the minister is working and in contact with other provincial governments right across the country trying to deal with it.

Again, I'm concerned about the limiting elements of this amendment as it's written, that somewhere down the road we may end up limiting ourselves through this. Mr Sterling has offered the suggestion that the way we could do this so that we don't tie up the whole legislation for ever and a day while this is in the courts is that it be proclaimed separately. That then raises another concern that I have.

I realize the Liberals have a motion that we'll be dealing with in a little while regarding package size. When we start talking about packaging, if that ability is left in the regulations section, in section 18, for all the intention that Mr Sterling wants to put in there, we can do that still, not to tie our hands or to limit ourselves in dealing with other issues and other elements that we might want to do as we try to deal with other packaging issues as might be.

If this is tied up, then we can't deal with that. We heard evidence about kiddie packs, for example, the minimum pack size, hoping that we would do something as a committee to change that. My concern is that as we hold this up and do not proclaim it while we wait for this evidence to mount and allow us to move forward, we actually then tie our hands and we can't deal with some of the other packaging elements of it.

I appreciate the intent and I think we're supportive of the intent, but I believe we can reach that through the provisions in section 18. Maybe we can take a look at what we have for section 18 and make a change there that would spell it out clearer. As Mr Sterling wants it stated a little bit more clearly what our intention is for the regulations, maybe we can spell out in the section that deals with regulations that we will deal with regulations around plain packaging.

**Mr Sterling:** I'd like to deal with some of the arguments here. I must say I'm extremely disappointed with the government's response to this bill as well as Mrs Caplan's response.

Number one, the national argument, this overall argument: I think the federal government has made its decision vis-à-vis plain packaging. They have said we're not going to have plain packaging in this country. That's basically what they've said at this time. They've made their regulations, they've made their deal with the tobacco industry that they're going to have larger warnings on the cigarette package, and I suspect that they're not going to deal with the issue again for a period of time. I don't know whether that's two years, five years or whatever. So I don't think we're going to get any leadership from the federal government on plain packaging.

The other part that I'm discouraged or disappointed



with the government on is that we talk about the national issue. Health care is a provincial matter. We have to take care of the outcome of what happens when people smoke and when young people smoke. Ontario taxpayers have to pay for the results of this and also the social costs involved with the downsides of taking on tobacco. So we have a provincial matter to deal with.

There are countries that are much smaller than ours—I'm given the example of Iceland, which has, I think, about 300,000 residents—which have their own packaging. So the whole idea that packaging can't be designed for a small population is ridiculous. We have a population of 10 million people and we have, I understand, somewhere between 25% and 30% of those who are smokers. I'll tell you, the tobacco industry won't have any difficulty in changing its packaging to meet these requirements.

Did the government not learn anything from our federal Liberal government vis-à-vis the drop in the tobacco taxes? These guys decided unilaterally, without consultation with this province, that they were going to drop the tobacco tax, along with Quebec, notwithstanding what Ontario thought. It was amazing, the quickness with which that action was taken in dealing with the whole issue of smuggling and tobacco taxes.

Do you really believe, Mr O'Connor, that this federal government is going to have plain packaging? I don't believe it. I don't believe it's going to happen as long as Mr Chrétien and the present Liberal cabinet are there. It's not going to happen. So your choice as an NDP government in your last year of power, if you really believe that plain packaging is important to cut down the consumption of cigarettes, is to take leadership.

That's what the Progressive Conservative Party of Ontario is saying. Notwithstanding what our federal government—we would prefer the federal government do this. Everybody would prefer the federal government do this so it would be uniform across this country. But you know, sometimes you've got to push them, as they pushed you on the cigarette tax issue.

I think it's time that this provincial government showed some real guts, not just talk on the street, Bob Rae slamming the federal government for lowering the tobacco tax. Now you have a chance to go ahead and show some real intestinal fortitude. Use the power you have in the Ontario Legislature to pass an amendment which is clear that plain packaging is coming in.

I'd also like to talk a little bit about the argument put forward by legal counsel. I'm glad to see that my colleague, and I guess the only lawyer in this committee other than myself, finds that the arguments put forward by legislative counsel are perhaps important but also may be grey in terms of which way you might pull on this kind of issue.

I wonder if the way section 5 is now written, where you do have a limitation on your general regulation—section 5, as legal counsel has written it, as the government has written it, can be challenged just as easily as and perhaps more so than what I have put in my regulation, because in your own proposal you have a general power under clause (a) that tobacco is packaged in

accordance with the regulations. That's your general power.

Now legal counsel have said you start to attack the general power when you put specifics in it. So what did you do in (b)? You put specifics in it. You said, "the package bears or contains a health warning or other health information in accordance with the regulations." So you have in your legislation which you've put forward a general clause and then you have one specific, and that's my concern. I think it's bad legislation the way it's written.

If you follow the arguments of legal counsel, you have one clause, you have 5(a), "the tobacco is packaged in accordance with the regulations." End of story; that's it. What (b) says to me, which is confirmed by the explanatory notes of this bill, is that this government's intent could be interpreted as strictly dealing with health information; nothing to do with plain packaging, nothing to do with the size of print, where the print is, what the colour of the package is, as is included in my resolution.

#### 1050

So I use the arguments which legislative counsel is putting to you as saying that your present section, as drafted, is much worse than the proposal that I've put forward. It has one single item which it specifies, and that is that you may make regulations dealing with health information. I'll tell you that will be the argument the tobacco industry will take you to court on if you pass this legislation as it is now. If you put in three or four sections, then a general section, they won't have nearly the argument that they will have under the present section.

**Mrs O'Neill:** I am going to be supporting Mr Sterling's amendment as well. I think that we have had a lot of witnessing and a lot of the witnessing has indicated the real contradiction we have in this province, and particularly in the country, with advertising. We have no advertising permitted, yet we know that advertising legally enters the country. We know and we've heard from several people, particularly the young people, that the package itself is the strongest advertisement because it re-enters and re-enters and re-enters the privacy of wherever we are.

The health-related associations that came before us I think to a person, and many of them with their own idea of what a package would look like, have brought plain packages. It's been one of the strongest presentations we've had and that's why I don't see how we can ignore it.

We've had something different in Ontario for a long time. I think for almost 10 years we've had the yellow strip which indicated whether or not tax has been paid. As far as I know, and I'm certainly willing to be corrected, that was unique to Ontario. It was a control mechanism. I think it worked in some case and in some cases it didn't.

We are always going to find that things are incomplete or, as I think Mrs Caplan said yesterday, there will be possibilities of litigation. There are many laws now that were bills that are in litigation; as we speak, in this

province there are two that are pretty high-profile.

To have stated day after day by this government that, "We have looked at the litigation possibilities," I'm really having difficulty accepting this argument when the intent of this bill has been so well received and now the intent is being destroyed, in my mind, by a government that's mesmerized by litigation. I know this government has spent a lot of money on litigation, more than I would like to have seen spent. But this isn't the bill that I want to suddenly become mesmerized or protected by; I'm sorry. I think that the youth of this province deserve this amendment.

**Mr O'Connor:** You know, I sit here and I listen to Mr Sterling's arguments from the Progressive Conservative Party and I have to think back to exactly what's been happening from the federal government in Ottawa. I'm not going to talk about the transfer payments that they were not giving us when they were in Ottawa, when they cut that because they didn't care about health care for the people of Ontario. I mean, that's pretty common knowledge that they did that.

Another common part too of knowledge was this here—

**Mr Jim Wilson:** Transfer payments went up every year.

**Mr O'Connor:** Jake Epp, the federal Tory—

**Mr Jim Wilson:** Mr O'Connor, they went up every year.

**Mr O'Connor:** —the Conservative Minister of Health went with and undermined their packaging legislation on advertising and came up with something that says it's okay to use it for promotional purposes. Well, excuse me, but we know where the Tories are at on this issue.

My concern is that we've heard on this committee time and time again evidence that states that they would like to see us moving on this. What I'm saying is, we don't want to lose that opportunity. Let's not lose that momentum. Let's not take away from parts of it, because what we do by limiting ourselves, putting it in here, is that for the research that's taken place—he himself brought up the fact that there could be litigation on this, so why limit ourselves to this?

Then what happens for the intention—I'm glad to see the Conservatives are coming around, that this is good legislation. We need to react to health issues, like when the college of pharmacy comes to us and wants us to move forward because it's a health issue and health care practitioners shouldn't be selling this. I'm glad to see that they're coming around that yes, this is a health issue and it's an important health issue—13,000 Ontarians dying every year from tobacco-related illness: Yes, it's a health issue.

But to not allow the research that's going on right now for the information that's needed for the social science studies that will allow us to proceed if we get forced into litigation, as being suggested, doesn't make sense to me. If we are going to move this forward, first of all, we should try to do it on a national level with all the provinces cooperative and as partners in this process. It's something that the federal governments haven't always

done, but we'll drive it from the provincial level to make it a national strategy right across the country. If we can't pull that off, then the intention is here. It's pretty clear.

You will note some amendments to section 18. I think we need to have that power in section 18 for regulations so we can move it forward, so that if things are challenged we have at least the opportunity to change a regulation if necessary so that the intention of all of the good legislators who are on this committee and all of the evidence that we heard from people can be met. We limit ourselves when we tie it to just putting it in the legislation and not giving ourselves the authority to deal with it in a fashion that's going to make sure that it's as effective as it needs to be.

So for the arguments that we heard, yes, I agree that we heard some very compelling evidence. We heard evidence from right across the province saying that this is a health issue, it's an accessory, it's something that does help sell it. That's probably why Jake Epp decided that he should go with this sellout to the tobacco industry.

But let's make sure that we can deal with this in a fashion that's going to allow us to keep this as something that's going to stand the test of time. We don't want to put in something that's not going to stand the test of time. We want to make sure that we are as progressive as we possibly can be so that all members of the Legislature of the province of Ontario can be proud that we've actually done something that's going to stand the test of time and not have something that's going to tie our hands so that we can't do what's been requested of us as committee members from the people who made presentations right across the province. Let's not tie our hands. Let's make sure that we can move in the progressive fashion that we all want to move.

**Mr Jim Wilson:** I want to just first say that it is politically expedient at the provincial level to point fingers at the federal government, and Mr O'Connor, regardless of the stripe of the federal government, talks about transfer payments being cut. I will give him till 1 o'clock today to table before this committee the proof that transfer payments have been cut from the federal government. They are up each year. They have been capped.

**Mr O'Connor:** They've been capped.

**Mr Sterling:** You said they were cut.

**Mr Jim Wilson:** You said there's a cut, and you said it was an undeniable fact—

**Mr O'Connor:** It adds to the health care costs of the province of Ontario.

**The Vice-Chair:** Mr O'Connor, one speaker at a time.

**Mr Jim Wilson:** I'm getting tired of seeing it in the media, and I'm getting tired of hearing it from the government. They are not cut. They go up each year by several hundred millions of dollars year over year.

**Mr O'Connor:** The share in the cost isn't being met.

**Mr Jim Wilson:** You might make the argument under the federal Liberal government now with Mr Martin's budget that they've been frozen at their current funding levels, but that never occurred under a Conservative



government in Ottawa. They went up hundreds of millions of dollars year over year over year. So let's just cut the crap.

Secondly, it detracts from the issue at hand. The issue at hand here is discouraging and stopping young people from starting to smoke. I frankly think it's hypocritical of you to simply say that is your intention and not put it in the legislation itself. I think that the people of Ontario are just tired of this type of politics.

**Mr O'Connor:** Tell me about the Tory Health ministers.

**Mr Jim Wilson:** They're tired of those picture politics you're holding up too, Mr O'Connor. I think they're tired of the whole bunch of us saying we have good intentions. You know the phrase about intentions.

The fact of the matter is that you have an opportunity here to strengthen this legislation, to actually meet the intentions and objectives of your own legislation, and we're willing to help you out in that process. I think you've taken the wrong attitude. The attitude Mr Sterling is putting forward is that we're here to help you with this legislation. Dragging in transfer payments just deters from the argument; it may be good politics. I wish in a moral way you would stop that sort of politics, because it's wrong. It's wrong to continue to put out falsehoods about this sort of stuff to the people of Ontario. I know it's expedient politics, but I thought we were moving into a new era of politics, and we'd better start responding to what the public wants or they will continue to be discouraged more and more about our political process. You have today the opportunity to restore faith in that political process by actually accepting an amendment that would put some teeth in this legislation.

**1100**

I think, on a personal note, you should be ashamed that you're dragging up the arguments that have been used time and time again to thwart this type of progressive legislation, that would be progressive if Mr Sterling's amendment were accepted. Then we could truly have pride in Bill 119 and we could truly say to the people of Ontario and say to the youth of Ontario that Ontario took a leadership role, rather than the smoke and mirrors that's been portrayed to date by this government.

**Mr Sterling:** You see, what happens in terms of the arguments that are put back to me on this amendment is that on the one hand I get the argument that the legislation as written is better than the legislation that I'm proposing. I don't agree, and I think section 5 is flawed at this time as it's written in the legislation and I think it will lead to litigation.

Litigation will occur regardless of what section is in there. It's a matter of who's going to win in the end. The tobacco industry has just got too big a stake in this to not take us to court. So whether your section's in or my section's in, there's going to be a lawsuit once this happens. If Ontario takes the leadership in going to plain packaging, they're not just fighting Ontario; they're fighting North America, because they will realize that once it happens here, it's going to happen in other jurisdictions.

You put that argument on the one hand, and then Mr

O'Connor turns around and talks about it being on a national level.

What is your position? Is your position for plain packaging or is it not? On the one hand, you're talking about this saying, "In fact we are for plain packaging," and on the other hand you're saying it should be done on a national basis. You can't have both arguments at the same time, because they conflict. They collide.

I really wish the government would start to work cooperatively on this legislation. I've been on this fight since December 1985 when I introduced my first private member's bill on this. That's nine years ago when I started this fight, long before any federal government started down the road in dealing with the tobacco issue in a serious manner.

I don't care which government does what. All I know is this: If people don't push, if they don't act as leaders, if they're not there pushing the extremities of this issue, then nothing happens, because the other side is so well financed, so well oiled, nothing happens.

You know what's going to happen here? If this very general section, section 5, passes, the tobacco lobby is going to be at your deputy minister's door day after day, because it can afford to be, at your assistant deputy minister's door, at Ruth Grier's door, at everybody's door in the Ministry of Health. They will put on a wonderful lobbying show in terms of why you can't just go as fast as you would like to go, why maybe we should do one thing this year and in another 10 years we should do something else.

If I were the Minister of Health, if I were Ruth Grier, I would say: "I want the legislation to rely on. I want to tell these lobbyists that the Legislature of Ontario has said clearly in its act that what we're doing is plain packaging." And when the lobbyists would come to me as Health minister, I would say to them, or my officials would have to say to them, or the bureaucrats would have to say to them: "Sorry, boys, lobbying's for naught. The Legislature has said clearly that there's going to be plain packaging in Ontario."

So let's get on with it. Let's get on with saving lives. Let's get on with turning young people off smoking. I'm really disappointed in the government's response to this amendment.

**Mrs Haslam:** I agree: I think we ought to get on with it. I am a firm believer in plain packaging; it's just that I don't want to tie our hands to lose another one. When you talk about lobbying, we all have been lobbied. We've been lobbied by the manufacturers of tobacco, we've been lobbied by the farmers, those of us in rural ridings, and we've stood our ground, like you stand your ground. I don't want to have us tie our hands so that we can't do what we really want to do, so that we put something in that ends up in the courts for a number of years and then we don't get what we want. I'd rather see us get what we want in an effective way.

Mr Sterling, we were just handed out an amendment. It says that a regulation made under clause (1)(d) may govern aspects of packaging including labelling, colouring, lettering, script, size of writing or markings and other

decorative elements. It goes on to say some other things. I would rather us be clever in how we do this legislation and not bumble through it saying, "This is a grandstand and we're going to demand plain packaging," and then have to swallow it because we don't have the right wording in our legislation to back us in the courts.

Talk to some lawyers. Talk to the lawyers for the health community. Talk to the lawyers who have to deal with this and see if this is not a better way and gives us more power to do what we want. I'd rather see us do what we want. I'd rather see us do what we really want to do, and that is, plain packaging, bar none—plain packaging. But I'd rather see us have something in place that will work. That's my concern, that we will put something in place that won't work, that will tie us, that will not allow us, through regulations, to put in place the plain packaging that we need.

We all know how backed up legislation gets. I would hate to see us have to find a spot where we have to go back into the legislation to change something. I'd rather see us put the opportunity in regulations so we can change the regulations and do what we have to do to be sure this works. That's where I'm coming from.

I agree we have to do something about plain packaging. I firmly believe that plain packaging is the way to go. I also believe the Minister of Health is talking, as Ms Caplan said, with other provinces so that we can do it on a stronger basis, on a national basis, where all provinces say: "Let's come to an agreement. Let's come to terms. Let's do this together," and not have one province say, "Well, we can't do that because we've tied ourselves into something that we are not going to have time to go back in and change."

Let's leave the minister room in the regulations, let's leave the minister room in her negotiations with other provinces, so that the end result is what we have in front of us, not grandstanding, not saying, "This is what we've done in this legislation, hurray, hurray." I'd rather take a long-term look at our long-term goals and give us the opportunity to reach those long-term goals in an effective way.

**Mr O'Connor:** The point here that needs to be made is that we heard from many people from the health community who said, exactly as Mr Sterling's amendment here says, "We feel that plain packaging will be effective in trying to keep our young people from taking up this deadly, addictive habit." The problem we have here is, whether it's done on a national level, and we hope that we can, or whether it's done on a provincial level, the evidence needs to be there. If this is going to go to litigation and is going to stand the test of time, then we have to have the evidence.

The health community is on side. They would rather us have the evidence and win this one. They would rather us have something that's going to be effective and something that's going to stand the test of time. It's not that anyone disagrees that plain packaging is an issue, but if we don't have the evidence that's necessary—whether it's fought on a provincial level, whether it's fought on a national level, we are going to need the evidence that is going to show beyond a doubt that this is why it's

effective and that it does have the effect that we're talking about.

We're convinced on this committee because we've certainly had a lot of people come to us and make strong presentations, but I think we would be turning our backs on all those people who came to us and made those presentations if we were to go out there and jump in with both feet and then have it not stand up in court. We would be turning our backs on all that's been presented to us. I wouldn't want for us to turn our backs on that.

I think there needs to be some time for the research to take place. That's why when we're dealing with this issue the discussion continues with the people from the health community. It continues with people like OCAT and its legal services people, because they themselves want to make sure that when we do proceed with this we are going to have something that's going to stand the test of time. Whether it's done on a national level or on a provincial level, we want to make sure that we're prepared so that we've got something that's going to stand the test of time for the health of those Canadians.

1110

**Mr Jim Wilson:** I have just two short comments and I know Mr Sterling wants to make some comments.

It seems to me, just so the public understands, that the current debate is whether the government should be doing this in some way in section 18 without specifying that the true intention of this section of the bill would be to go towards plain packaging or whether it should be done in section 5 up front so that when people pick up this piece of legislation they know what the specific intention of the Legislature is with respect to plain packaging.

Unless I've totally flipped my lid, the heading of section 5, so the public realizes, is, "Packaging, Health Warnings and Signs." The side bar subtitle is called "Packaging requirements." Where in the world else in this bill would you put something to do with packaging except in the packaging section, which is section 5, Mr O'Connor? I can't make the point strongly enough.

Secondly, you talk about evidence. I just want to refer to the pharmacy issue. You don't have evidence, other than hearsay, that somehow the ban on selling tobacco products in pharmacies, not allowing pharmacies to sell a legal product, will reduce consumption. I assume your defence, as we discussed yesterday, is probably using the clause that says things can be justifiable in a free and democratic society. Sorry; I can't remember my constitutional law courses. We should have brought the charter with us. I assume you're using the all-encompassing argument to justify your ban at pharmacies. There's where you're going to have a real legal argument, because you don't have the evidence at all.

There is far more evidence, and very compelling evidence, in support of plain packaging. Lots of tests have been conducted among young people to prove that plain packaging does have an effect in ending the appeal of smoking, or wanting to take up smoking.

Those are my comments. I know Mr Sterling wants to add to that.

**Mr Sterling:** I think Ms Haslam has a good point.



Because I see legal counsel in the audience—I believe he worked closely with the health lobby on this issue—Mr Rob Cunningham, I'd like to seek his advice as to what kind of clause would be best to put in here to indicate (1) the intention of plain packaging and (2) which clause would in fact not lead to an unsuccessful fight in the courts. I ask you, Mr Chairman, if perhaps we can have Mr Cunningham step up to the table and seek his advice at this point in time.

**The Vice-Chair:** What is the committee's wish in this regard? You've heard the request of Mr Sterling.

**Mr Jim Wilson:** Agreed.

**Mr McGuinty:** No objections.

**The Vice-Chair:** Please state your name and position, and proceed.

**Mr Robert Cunningham:** I've had a chance to confer with a colleague of mine who is not in the room right now. I've seen the proposed government amendment to section 18 and I've seen Mr Sterling's proposed amendment. In my view, if the final act contained either of those provisions, the act would have enabling authority for the cabinet to require plain packaging.

**Mrs Caplan:** Did I hear you say either was—

**Mr Robert Cunningham:** Yes. Now, Mr Sterling's amendment, if it was to be adopted and found in the act, would perhaps put greater pressure on cabinet to enact plain packaging because it specifies things early on in the bill with the Legislature wanting the cabinet to the move forward quickly. If it's contained in section 18, while the authority is still there, perhaps the Lieutenant Governor in Council would not act as quickly.

**Mr O'Connor:** I guess the importance here is that there has been money granted to take a look at this issue. I believe it's the Robert Wood Foundation that has actually given money to the Centre for Health Promotion to do some research on this issue. We end up tying our hands if we don't allow them to at least finish their studies and research so that we can do something that's going to stand the test of time. I think the key here is that if we limit ourselves to this, we end up with something that may not stand the test of time and then we end up losing. What we've done then is we've done a disservice to the health community, and I don't want to do a disservice to the health community.

**Mrs O'Neill:** I'd like to ask the lawyer who just presented his opinion. I taught grammar, as I mentioned yesterday, and I see quite a difference between section 18 and section 5 as proposed by Mr Sterling. One says "may" and one says "shall," and if I remember my teaching days, there's quite a difference between those two. You know, you intimated that there may be more pressure on the cabinet. I would suggest there's much more of a directive on the cabinet.

If I may also, at this moment, faxes, I'm sure, are coming into all of our offices. I think I'm getting about 25 faxes a day, even as we do clause-by-clause, which is most unusual. This bill has extremely high interest. Of two that I got either late yesterday or early this morning, one from the eastern Ontario health unit says, "We are very supportive of the many provisions of Bill 119 which

affect our young people," and then says, "Support plain packaging." This particular group, and this happens to be a medical group, thinks that Bill 119 supports plain packaging, and it does, in a weird, distant sort of way.

However, the regional municipality of Ottawa-Carleton also sent me a fax this morning that states, "In order to help counter the effects of lower taxes, Bill 119 needs to be strengthened by specifying generic packaging in the legislation rather than through regulation."

People out in the community are very aware of what's going on here, and I really do think there's quite a bit of doubletalk. I don't know whether the lawyer wants to respond to my interpretation of "may" and "shall," but there's a great deal of difference from what the government has presented to us. It's really not much different than was originally presented, but it—what should I say?—becomes a little more specific what they're going to do. But I see here "and other decorative elements." What in heaven's name does that mean? We're getting into the information syndrome that we were in yesterday.

**Mr Robert Cunningham:** Yes, there is a difference between the words "may" and "shall," but in Mr Sterling's amendment it doesn't say that the cabinet "shall" require plain packaging, but if plain packaging is required, then everyone shall obey in terms of retailers and so on.

**Mrs O'Neill:** Right.

**Mr Robert Cunningham:** The same types of thing would apply with the current versions of section 5 and section 18: If cabinet requires plain packaging, then everyone shall obey it and not sell it and so on.

**Mr McGuinty:** Just to go back to the fax that my colleague received this morning, it seems to be at odds and maybe it's just because the folks in the Ottawa-Carleton health department haven't been fully briefed. I mean, why is it that they're telling us that we should be specifying generic packaging in the legislation rather than through regulations? What, in your opinion, is the best way to ensure that we can implement generic packaging, if necessary? Is it through Mr Sterling's motion or is it through the new government amendment that is going to amend section 18, which you had an opportunity to review?

**Mr Robert Cunningham:** First of all, the health community sees plain packaging as the most important thing that it could do, other than taxation, in terms of controlling tobacco use—

**Mrs O'Neill:** Right on.

**Mr Robert Cunningham:** —particularly among young people. Right now, there is authority for cabinet to require plain packaging under either of the proposed amendments, if they were to find themselves in the current act.

There is another alternative. First of all, it's important to ensure that there be some regulatory flexibility. The tobacco industry is extremely creative and will have every loophole exploited to the extent that's possible. So at a minimum there must be a residuary opportunity to regulate things that you don't think of the first time around. They're always very creative. Another alternative

that's not yet before you is you could require some minimum standards in terms of plain packaging right in the legislation in terms of the size of a provincial health warning or the size and the placement of brand names, and then everything else required by regulation. So you could have that alternative, which is not yet before the committee.

1120

**Mr McGuinty:** Okay. I'm going to ask that question again. I appreciate all the information.

**Mr Robert Cunningham:** What you could do in the act to get as close as possible to plain packaging—the best alternative would be to provide some minimum standards that would come into force in the act and some further provisions to enhance the plain packaging that could be prescribed by regulation.

**Mr McGuinty:** Okay. What we have on the table today is we've got Mr Sterling's motion and we're going to be dealing later on with the government's motion, which amends section 18. Which will serve us better?

**Mr Robert Cunningham:** The best alternative would be a third one that's not one of those two. It would be a modification of Mr Sterling's.

**Mr Sterling:** But, Rob, we don't have that choice because we don't know enough to do those things. I would have loved to do that in my motion, but quite frankly I don't know enough in terms of the size of print, the type of print, the size of the package. I don't buy cigarettes, so—

**Mrs O'Neill:** Maybe you could buy one package for this purpose.

**Mr Sterling:** No, I wouldn't even buy one for this purpose.

My amendment to section 5 was to try to be as specific as I possibly could, but let those who would look into the actual physical details of the packaging. We don't have that choice. We have a choice—I don't want to put you between a rock and hard place in a way—between my amendment or putting it in section 18. Basically, that's it.

Maybe legislative counsel can—

**Mr McGuinty:** Don't let him off the hook yet.

**Mr Sterling:** I'm not going to let him off the hook.

**Mr Jim Wilson:** He's not on the hook.

**Mr Sterling:** Well, I think you indicated that there would be a greater propensity for a cabinet to take section 5 seriously than section 18.

**Mr Robert Cunningham:** I did say that, yes.

**Mr Sterling:** So you're saying that mine is preferable in terms of having real action rather than the other?

**Mr Robert Cunningham:** From a political point of view, I would certainly think that it would, yes.

**Mr Sterling:** As a lawyer, I know enough not to ask too many questions when I don't know—

**Mr McGuinty:** You have to know when to stop.

**Mr Sterling:** That's right.

**The Vice-Chair:** Thank you, Mr Cunningham, for your help to the committee in answering questions.

**Mr O'Connor:** Mr Chair, I guess I've got a concern

about process here at this point. I want to make sure that we have as full a consultation as we can. Some of that consultation will need to take place over the regulations, and there are some concerns about some areas, whether or not they're going to stand the test of time or what not.

What I'd like to do is ask our legal counsel then to take a look at what I've got proposed that we will be dealing with in section 18 and whether or not our section 18 is going to give us the ability to do things without tying up the other packaging elements that we may wish to deal with at the moment without having the opportunity for us to lose things because we don't have the information necessary and without having the opportunity for us to lose the plain packaging issue that we all here in this room are really concerned about because we don't have the evidence when this ends up before litigation, if that's the case, as it most likely will be.

So my question to legal counsel is, is it your opinion that we could end up losing other parts of this, and will it be tied up as we try to deal with it?

**Mr Williams:** With all due respect to my colleague—I think to some extent we're all fighting the same battle in this committee; I'm here as legal counsel to the ministry, but to some extent I'm also counsel to this committee, to give it the best advice I can give as to how I would advise the ministry how to draft the particular sections of the bill—my view is that Mr Sterling's amendments do not say the same thing as the amendment you have before you to section 18. I think section 18 is broader, it's more general and it gives us the authority we want should we be challenged by the tobacco manufacturers in court. I think it's probably fair to say we will be challenged by tobacco manufacturers in court.

My view is that the wording has to be very carefully crafted. We're in a committee. It's difficult, because we have a very short time frame to come up with words that are adequate to do what we think will do the job. In my view, section 5 as it's presently drafted by Mr Sterling's amendment doesn't quite get us there. My view is that the words we have in section 18, as you have before you, are better from our perspective to do what we want to do.

**Mr Sterling:** You're saying that with knowledge of my amendments to section 18 as well, are you? Are you reading those in conjunction?

**Mr Williams:** That's correct.

**Mr Sterling:** I have two sets of amendments, one to 5 and one to 18. Would you feel more comfortable if you were given more time to deal with the language?

**Mr Williams:** No. I think I've looked at what you've got, what I've heard from the various health groups as to what they're interested in seeing in the legislation, my instructions from the ministry, the wording that I've put forward and I've helped craft, and section 18 I think is sufficient to do the trick.

**Mr Jim Wilson:** I guess my concern is more of a political nature. I'm less concerned with the legal means to getting to plain packaging. That's why legal counsel can't really answer. We should stop deferring to legal counsel about the political question; that is, does the government today have the will and is it willing to



commit totally to plain packaging? We've not had a direct answer on that. The attempt to deal with section 5 by Mr Sterling is an attempt, and Mr Cunningham confirmed it, that politically, if it's in section 5, we have the clear words of the government, words of the legislation, that tell us that cabinet won't sit on their hands and be vulnerable to the tobacco lobby, as we've seen the federal Liberal government more recently, but will actually move ahead with this.

I assume we're going into an election in the next 12 to 15 months or thereabouts. The tobacco lobby has a wonderful ability to muddy the water and tie things up, and if this bill is not passed with a very clear intention—I'd even say, put dates in to move towards plain packaging. The government's been hung up on dates when it comes to putting some people out of business like pharmacies, yet it won't show the same determination and effort in doing something that could really help to meet the objectives of this bill.

That's the challenge. It's a political challenge. I don't think I would feel comfortable leaving this committee or passing this on third reading if I knew it was going to be strictly up to the cabinet, which at some unspecified time in the future might get around to doing something about plain packaging. I see that as no better situation than the current law in Ontario, which is no law essentially, dealing with plain packaging. If we're here to improve the law, to improve the plight of young people and to improve the health of the province, then let's put it up front in the legislation.

**Mr McGuinty:** I think we're getting into an area here where it's obviously complex. We're trying to anticipate the moves of another party. Mr Sterling has put forward an amendment. The government prefers to deal with that amendment through the regulations. In all frankness, I'm not sure which is better. What I'm going to do is simply put on the record that the government is going to have to assume responsibility for this. It has access to an army of experts who have addressed this issue. My concern is to ensure that the Ontario government has in its back pocket the ability to deal with any and all kinds of issues related to packaging.

I do not believe the Ontario government should be moving on plain packaging today. I don't think we've explored all of the opportunities yet at the federal level, but I want to have that ability in the event that when you'd use it—and as I say, I don't have the time or the resources at my command to deal with this issue and I'm leaving it in your hands.

1130

**Mrs O'Neill:** I'm having a lot of difficulty. I guess I'm having the same difficulties Mr Wilson is about political will because I've heard only two members of the government talk to this issue. I find that I have another fax here from Ottawa-Carleton Council on Smoking and Health which just conveniently reminded me that Mr Laughren, our Treasurer of this province, the day he announced that he had to do this despicable thing of lowering the tax, which many of us don't feel is a good move but some of us feel was inevitable, said that day that the next step had to be plain packaging. He's the

Deputy Premier of this province.

So what are we having? We're having a government that is being extremely wishy-washy. Let's face it, folks, and I'm sorry to remind you, but you have flip-flopped on many decisions: Sunday shopping, and do I need to begin the list? Things that you say are very dear to you, you do not follow through until you're really cornered. There's not much time left to be cornered on this issue. The mandate's coming to an end. Here again, this particular group says, "legislate plain cigarette packages in Bill 119." I will be supporting Mr Sterling's motion.

**Mr Sterling:** I want to make it clear to the committee that this amendment is not my drafting. I went to legislative counsel and I said, "This is what I want to achieve, and what I want to achieve is plain packaging." What I received back was an amendment to section 5 and to section 18.

So on the one hand, we have—I don't like to put people in conflict—one legislative counsel saying, "This is the way to do it," and another one saying: "This is not the way to do it; there's another way to do it. Let's do section 18 alone."

We hear evidence from people here that there will be more political pressure, it will be more up front to have it in section 5. Leave it at that. That's the way it is. Presumably both are written by skilled people in this area. Therefore, I would assume that both achieve ultimately the same end, if that's the argument of the government. But if one is preferable in a political sense, which is mine, let's choose it and do it.

**The Vice-Chair:** Mr O'Connor advises that Mr Williams will respond.

**Mr O'Connor:** I guess before I turn the total response over, though, the key here is that legal counsel working for the Ministry of Health have had the benefit of much consultation that legal counsel for government members and members of the Legislature have at their disposal. So, you're right, there are some parts of this that not everybody has a choice and we could make things political but that's not the thing here.

The point here is that we want to try to act on the wishes of what's been presented, on behalf of what the health community's presented, and we don't want to end up losing something and that the tobacco industry's the one that wins in this and not the people we're trying to worry about here as members of the Legislature and the health of the people of Ontario. I'd ask Frank Williams to comment a little bit further on the drafting.

**Mr Williams:** I don't have much to add to Mr O'Connor's comments. I think Mr Sterling's remembering a past life of mine when I was legislative counsel. I'm now counsel for the Ministry of Health. I think it's correct that—I don't mean that in a negative way. We worked for a long time together in other venues.

But I think Mr O'Connor is correct in saying that legislative counsel—certainly when I was at legislative counsel office, you look at things from strictly a drafting perspective. Now I'm with the ministry and I can look at it from not only a legislative counsel perspective but from

some of the concerns that, as a government lawyer, I would have if I was potentially challenged by the tobacco industry. Some of those concerns have been taken into account in the draft that we've produced.

I can't go much beyond that for the reasons I stated yesterday with respect to legal opinions, but certainly some of the things that I've considered have taken into account possible challenges that we would have from the industry.

**Mrs Haslam:** You know, we've spent an hour and a half arguing over something we all agree on. We all agree on plain packaging and we think that is the way we should be moving.

**Mrs O'Neill:** That's not what the Premier is saying.

**Mrs Haslam:** I think we disagree on the type of wording that will get us there. So we have discussed for an hour and a half two separate entities that will get us to our goal. I think we should now make a decision and perhaps vote on it and go on to other aspects of the legislation that are just as important, if not more important. I think we've heard from many different sides of this story.

I would just like to say about Ms O'Neill's comments, I think the Treasurer was speaking very honestly. The fact that we had to lower those taxes is just reprehensible. I think that was the worst thing the Liberal federal government could have done to us as a province. I think we all are in agreement—

**Interjection:** They've done worse since then.

**Mrs Haslam:** Please, we all agree that we have to do something in this legislation to look after this issue, and I think we now have to make a decision. I would like to see us do that.

**Mr Jim Wilson:** I would disagree with respect to Ms Haslam's comments. I think this is the most important issue we could deal with in this legislation, and we wouldn't even be talking about it for the last hour and a half if Mr Sterling hadn't pushed the issue, nor would we see the government in a panic to amend parts of section 18 to try to look like you're committed to this.

**Mrs Haslam:** We're trying to do something together. You don't seem to understand that.

**Mr Jim Wilson:** What I haven't heard yet and where we disagree still is the fact that we do not have a firm commitment from this government to move on plain packaging.

Mr Sterling hasn't been coy or shy about it. He's put out a press release that says, and I'll quote from the press release: "I want it crystal clear that the Legislature of Ontario is saying that plain packaging in our province is about to happen. We cannot trust the federal Liberals to act, as they have apparently been captured by the tobacco lobbyists," said Sterling. "Plain packaging would have the added advantage of clearly distinguishing legally sold tobacco from smuggled cigarettes." It's clear where we stand on this issue.

What is not clear in this debate is where the other two parties stand on this very, very important issue—

**Mrs Haslam:** Yes, it's very clear. It's clear we like

plain packaging.

**Mr Jim Wilson:** —an issue that is the most important issue in this act, an issue that you've waffled on from the beginning to the end. It's time to put your words into action and tell us whether or not you're committed to plain packaging in this province, regardless of whether the federal government eventually comes around to its senses on this issue or not.

*Interjections.*

**The Vice-Chair:** Mr Wilson has the floor. Please continue.

**Mr Jim Wilson:** That is what is absolutely clear.

**Mrs Haslam:** I like to give him a shot of his own tactics.

**Mr Jim Wilson:** Fine. Fair game. It still doesn't deter me from saying what I want to say.

**Mrs Haslam:** It doesn't deter me either.

**Mr Jim Wilson:** I think that we need a commitment from this government. As humanly possible, we're going to do everything today to make sure you make that commitment and do not get away with waffling.

Mrs O'Neill is quite correct. I recall the article and I recall the Treasurer's response as he wiggled his way out of caving in to the cigarette tax issue. In an effort to do that, he got away with the press that day by saying: "We're going to move. Plain packaging's the answer to that." I don't think you can say one thing to get yourself out of tight situations in press scrums and then not come forward in an honest way in legislation to back up what you've been saying all along outside this room. So push comes to shove. It's right now and we want to know what your commitment is.

1140

**Mr Sterling:** This issue of plain packaging, I think, is far more important than the combined effort of Bill 119 in terms of everything else it tries to do. I believe plain packaging would have a larger impact in terms of consumption of tobacco in this province than Bill 119 altogether. In fact, I'm absolutely convinced of this. I don't think this committee should mind devoting significant time of the clause-by-clause to deal with this issue.

One of the problems we're faced with here is that legal counsel is saying to us that there are limiting factors in what I'm putting forward, or that's the allegation of one side of it. I think it would do us well, Mr Chairman, to have over the lunch-hour the legal counsel review the government's amendment to section 18 and my amendment to section 18, which goes hand in hand with my section 5, and come back and tell us what are the limitations of my amendment. Legal counsel can't, I don't think, come in front of a committee and say, "Your amendment limits us but because this section may come into legal battle some time down the road, I'm not going to tell you what in fact those limitations are." I can't buy that as a legislator; I'm sorry. I think I have to know and if in fact there are significant limitations on what I'm putting forward I'll bow out, because I want plain packaging, but I think that quite frankly the legislation is written for a number of reasons. One is for lawyers but the more important one is for the people.



I'll tell you, if the section is written as it is under section 5 in terms of packaging requirements, I defy most lay people from picking up this act, turning to section 5 and seeing plain packaging in that. If they pick up the act and it was amended, as put forward by my particular amendment, people would have a clear idea what this government was about and I think that's why Mr Cunningham was giving us advice that we put a lot more pressure either on this government or subsequent governments to take real action in putting these regulations forward and putting plain packages on the shelves of our stores.

We're getting close to lunch-hour. I would really like to know what limitations the counsel are talking about in terms of the amendments I put forward, and I have said before I'm quite willing to move constructively in amending either my one to section 5 or section 18 in order to make it less limiting on the government, but I think it is much more preferable than the belated amendments of the government to section 18.

I suggest we adjourn for lunch at this time and come back at 2 o'clock, 1 o'clock, 1:30 or whatever time suits us, and we can hear then from legal counsel as to why my particular amendment is limiting.

I think it's more important than letting it go and being frustrated that this debate has been long.

**Mrs Caplan:** If it's appropriate, Mr Chair, I'd like to move that we put the question on this section, this amendment, at this time. I think we've heard everything legal counsel has to say, and in the interests of moving along with this debate and this discussion, before we adjourn for lunch I move that we vote.

**The Vice-Chair:** You've heard Mrs Caplan's motion. All in favour?

**Mr Jim Wilson:** Mr Chairman, I would like 20 minutes to retrieve Mr Sterling—

**Mr O'Connor:** He heard the motion.

**Mr Jim Wilson:** —to vote on this motion, and it's our right to have a 20-minute recess.

**The Vice-Chair:** Is it possible we could shorten the recess?

**Mr Jim Wilson:** No.

**Mr Donald Abel (Wentworth North):** We know where you're coming from.

**Mr O'Connor:** The Tories are doing it again.

**The Vice-Chair:** It's a 20-minute recess. Is this a request for—

**Mrs Caplan:** Mr Chairman, would it be possible that we just adjourn now? I'll withdraw my motion and place it again at 2 o'clock.

**Mrs Haslam:** Nice try, Elinor. I agree that we've got to go ahead with this thing.

**Mrs Caplan:** Stop playing games with this. We don't want to play games with this.

**Mrs Haslam:** This is a show. This is ridiculous. All of us agree on where we want to go. We understand we want to get there. This is a shame.

**Mrs O'Neill:** Mr Chairman, before we adjourn, I had

asked for a couple of things. We're getting very close to the end of this committee and I had asked for a list of the interventions that had been placed to assist the tobacco growers. I haven't received that yet. I think there maybe was more than one ministry involved.

The other thing we had asked for the last day, which I thought we all thought was important and now people are asking me about, was the letter that we were to write to the Minister of Labour regarding the workplace smoke. Are any of these things forthcoming? We have only one and a half days left.

*Interjection.*

**Mrs O'Neill:** Well, I don't know. Maybe I didn't see it. I haven't had it presented to me. Okay. I just wanted to bring those things to the attention of the committee because I don't want to let them be lost.

**The Vice-Chair:** Your requests are noted. Is it in order to adjourn until 2 o'clock?

**Mrs O'Neill:** I'll be asking again at the end of the day.

**The Vice-Chair:** Thank you for your participation. The committee now stands adjourned until 2 pm this afternoon.

*The committee recessed from 1146 to 1409.*

**The Vice-Chair:** Good afternoon, ladies and gentlemen. The social development committee is now in session, reviewing An Act to prevent the Provision of Tobacco to Young Persons and to Regulate its Sale and Use by Others, Bill 119. When we adjourned, we were discussing Mr Sterling's amendment to section 5 of the bill. Are there any further speakers regarding that particular amendment at this time? If not, we'll vote on Mr Sterling's motion.

**Mr Sterling:** A recorded vote, Mr Chairman.

**The Vice-Chair:** Recorded vote requested? Yes.

All those in favour of Mr Sterling's amendment to section 5?

**Ayes**

McGuinty, O'Neill (Ottawa-Rideau), Sterling, Wilson (Simcoe West).

**The Vice-Chair:** Opposed?

**Nays**

Abel, Caplan, Carter, Frankford, Haslam, O'Connor.

**The Vice-Chair:** The motion is lost.

Liberal amendment to section 5 of the bill, Mr McGuinty?

**Mr McGuinty:** Yes.

**Mrs Haslam:** Could I have a clarification?

**The Vice-Chair:** Yes.

**Mrs Haslam:** I have in my hand two of Mr Sterling's amendments.

**The Vice-Chair:** Yes, there is a further written PC motion that I was going to go to next, because it was delivered this morning.

**Mrs Haslam:** So it is a viable amendment. That's what I'm asking.

**The Vice-Chair:** It's my understanding that it can be

submitted at any time and it will come up next.

**Mr McGuinty:** Just so committee members are clear, I submitted an amended version which the clerk handed out earlier. It just contains a few handwritten words after the end of my original amendment.

**The Vice-Chair:** You'll read the amendment?

**Mr McGuinty:** I will read it right now.

I move that section 5 of the bill be amended by adding the following subsection:

"Same, cigarettes

"(2) No person shall sell or offer to sell cigarettes at retail or for subsequent sale at retail or distribute or offer to distribute it for that purpose unless the cigarettes are contained in packages of at least twenty cigarettes or such greater number as may be prescribed by regulation."

What I'm addressing here is this issue of kiddie packs, which are cigarette packages that contain fewer than 20 cigarettes. One of the things we learned during the course of our hearings was that there are three things which can induce kids, and again we're focusing on what I feel is an important advance being made on this bill in so far as it relates to children or young people. Kids are going to start smoking if the cigarettes are accessible, if the packages are attractive and if they don't cost too much. One of the ways that you can address the issue of cost is through the number of cigarettes contained in a package.

I understand that under the existing section 5 it could be argued that authority is in there now to specify the minimum number of cigarettes that would be found within a particular cigarette package, either through section 5 itself or in the regulations. But I would prefer, as a number of presenters have mentioned, to codify this in section 5 itself, specify the number of cigarettes that we're talking about and put everybody on notice. We're not leaving it to regulation. It certainly lends me greater comfort. I personally feel that it's very important that what we're effectively doing here is establishing a minimum price for cigarettes by stipulating the number to be found in a particular package.

As I say, I've left it open-ended so that we could, if the government decided it was appropriate in the circumstances, increase that number beyond 20. But I felt that 20, based on information that I'd had when I was researching my own private member's bill, seemed to be kind of the sawoff in terms of a traditional adult-sized package, if you will. Normally adults don't go in to buy their cigarettes in any quantity less than 20.

**Mr O'Connor:** I appreciate the amendment. I think in its original form I certainly would have had some difficulty with it because, as I've stated in this section, we've dealt with this by referring much to regulations. I don't think you've taken away from the intent of that with your change to your amendment. I think it's a shame that we saw the lowering of the price, because that's probably one of the realities that we heard originally, that the price was a rationale. Hopefully at some point in time we'll see a nationwide change that would see that reversed and then that price argument would certainly stand up.

The five-packs: We saw the five-pack as we were

travelling on committee. Some of us had never actually seen that five-pack as presented and now realize that is a reality, and the 15-pack. It certainly is a concern. When a child can go and purchase a package of gum or a package of playing cards and the cigarettes are cheaper, then it certainly has an appeal. Next thing you know, you end up with the addiction after they've started taking up this habit without knowing how addictive it really is.

I support the move and appreciate the change that you've got to recognize the need for the regulation authority in section 18 as well.

**Mr Jim Wilson:** I just wanted to indicate our caucus's support for this amendment.

**Mrs Haslam:** Could I have a clarification? Has Mr McGuinty withdrawn the original motion or is he amending the original motion?

**The Vice-Chair:** He's placed this motion in place of the previous one. That's how I understand it. He's moved this one. Does that complete your question?

**Mrs Haslam:** Yes, I just wanted to be clear on that.

**Mrs Caplan:** I would very much like to speak in support of this particular amendment. I know that this is the sort of thing that can be effective just in Ontario, even if you don't have a national consensus, because it does deal specifically with an item for sale in Ontario retail outlets.

One of the other things that I know is happening—and I think this amendment covers it, but it's a question for legal counsel—is that there are some retailers who are actually opening up existing packages of cigarettes and selling them one at a time. I want to know if this would stop that practice.

**Mr Williams:** I believe it's actually illegal to do that now, but certainly this would enforce that message.

**Mrs Caplan:** It would reinforce that message?

**Mr Williams:** Yes.

**Mrs Caplan:** You mention that you think it might be illegal to do that now.

**Mrs Haslam:** That's correct.

**Ms Brenda Mitchell:** Under tax law.

**Mrs Caplan:** It's under tax law, but under this specific—you see, I would think most people don't even know that.

**Mr Williams:** I think you're probably correct. I think provincially certainly there's nothing in place now, but this would double the effort, so to speak.

**Mrs Caplan:** So there's nothing in place in provincial law. It would be a federal tax thing that would make that. That's probably why nobody is aware of it. If it could be included in this legislation that it is illegal in the province of Ontario, that would reinforce the federal prohibition against breaking open existing packages and selling cigarettes one at a time. I think that would be a very important and progressive move and I hope that will be included in the legislation.

**Mr Williams:** There's also further authority in the regulations. If the government wants to govern packaging of cigars or other tobacco products, that can be done as



well. That would be fine.

**Mr Sterling:** I find it interesting to find the rationalization why this can be provincial by Ms Caplan vis-à-vis the plain packaging. I find an interesting, almost specious, distinction between the two. Be that as it may, I support this amendment to the legislation.

Can you clarify for me, where do the jurisdictions cross over? The plain packaging kind of amendment, I would think, could clearly be argued was in the provinces's right to deal with the labelling issue in that regard, as a health care issue. When you're talking about the number of cigarettes in a package, I don't know who has the right to control how many bottles or how many cigarettes or how many things are in a package. Is there any distinction? It's more a question; I don't know.

**Mr Williams:** I've got to admit, I've never thought of it quite from that perspective. Certainly the provincial and the federal powers, as you know, depending on what's being regulated, tend to overlap. Provinces have the authority to deal with matters concerning health. The general authority for the federal government is peace, order and good government, which covers, in essence, everything.

1420

There tend to be things in law that do overlap and the jurisdictions overlap, and sometimes it's very difficult to separate out the two. But as far as regulating how many items you can put in a package, I never thought it was necessarily either jurisdictions; neither one prevailed necessarily over the other, I wouldn't think.

**Mr Sterling:** It was just a matter of interest, that's all.

**Ms Jenny Carter (Peterborough):** I also would like to support this amendment for the obvious reason that it would make it harder for kids who hopefully don't have unlimited supplies of money to buy cigarettes. But as someone who has also taught grammar, shouldn't "it" in the third line be "them," just as a housekeeping change?

**Mr McGuinty:** I'll defer to my draftsman.

**The Vice-Chair:** The draftsman?

**Mr McGuinty:** Legislative counsel.

**Ms Sibylle Filion:** Yes, you're quite right. Thank you.

**The Vice-Chair:** Further discussion? If not, you've heard Mr McGuinty's motion to amend section 5.

All in favour of the motion? Opposed? Carried.

PC amendment to section 5, the one that was handed out today and is written out.

**Mr Sterling:** I'm not going to put that amendment forward, Mr Chairman.

**The Vice-Chair:** You're not presenting?

**Mr Sterling:** No.

**The Vice-Chair:** Thank you.

Section 5, as amended: Those in favour? Opposed? Carried.

Section 6: There's a government motion to amend section 6. Mr O'Connor.

**Mr O'Connor:** I move that section 6 of the bill be amended by adding, after "health warnings" in the third line "and other information." This would be consistent

with the amendment made to clause 5(b).

**Mrs O'Neill:** Again I find this very difficult. I find that this morning, as late as this morning we heard the words, "This is a health issue, this is a health issue, this is a health issue," and even in the explanatory notes of the bill that same idea was there and all of a sudden now we get other information.

I'm sorry, I just don't see the logic to it. I don't think it's needed. There are other ways in which to get other information to people. We're dealing with this from a health aspect and all the presenters who came before us were coming before us with that kind of an intent. They didn't have any other ulterior motive, whether it was to certain retail practices or manufacturing practices.

**Mr McGuinty:** I find it passing strange as well that we are thinking of incorporating other kinds of information in here and I would make the same arguments I made with respect to the previous government amendment which wanted to add other information as well. But I'll take the opportunity to ask the parliamentary assistant what it is that he had in mind. Why is it necessary to broaden the kinds of information beyond, I guess, health warnings? What is it he's got in mind?

**Mr O'Connor:** I appreciate the opportunity to offer some clarification. Of course this deals with the signage in the retail establishments and there may actually be a wish to put on things, for example, such as "Smoking is Addictive." Again we can say that's a health matter and someone could take issue with it. I think to try to be as inclusive as we possibly can, if we allow ourselves the possibility of putting other information on there, then people aren't going to be able to judge it just on that alone.

It's consistent with what we heard from people like the Ontario Campaign for Action on Tobacco, the Etobicoke Board of Health and the Non-Smokers' Rights Association. They came to us with this as a suggestion.

**Mrs O'Neill:** Well, I didn't hear them present it in the committee. Maybe they did but, boy, I sure didn't hear them. They would never have suggested removing the word "health."

**Mr O'Connor:** No. They're adding "other information." We're talking about signs.

**Mrs O'Neill:** I know you're adding "other information," but you're taking the emphasis off health. You can add "other health information," but no, it's got to be "other information." We'll find out what this means in due course.

**Mrs Caplan:** The question I would have of legal counsel is whether you would consider a message that says "Cigarettes can kill you" as being part of health information, or just to be helpful, what kinds of messages you could foresee wanting to include that would not necessarily be health messages.

**Mr Williams:** It's the old story, some things are black and white and others are grey and in between, but I'll try not to sound like a politician when I'm answering this. Certainly things that mention your health or the fact that you could die I would consider as health information. When you're getting into smoking cessation, I tend to

think of it not as health information. I just want to make sure that, if we want to have signs in stores or signs on packages which are in that grey area or go beyond what the court might consider health information, we're covered. That's really my concern.

**Mrs Caplan:** Do I understand your intention in removing the word "health" is to allow you greater scope to include prevention and cessation—

**Mr Williams:** To broaden it.

**Mrs Caplan:** —as well as explicit messages that say, "This can be injurious to your health"?

**Mr Williams:** If you want it to be redundant, I know legislative counsel—

**Mrs Caplan:** "Health and other information." I thought you were taking the word "health" out.

**Mrs O'Neill:** We took it out yesterday.

**Mrs Caplan:** So you're adding to it.

**Mr Williams:** If you were to be redundant—legislative counsel will say this isn't necessary, and if I were still sitting as legislative counsel, I'd say the same thing—you could say "health information and other information." I'd be content with that.

**Mrs Caplan:** I see. So this is just to be doubly sure?

**Mr Williams:** That's correct.

**Mr O'Connor:** Even in the arguments we had yesterday, one could argue whether or not it would be an appropriate place on the packaging element that we dealt with yesterday, "Cigarettes can cause forest fires," whether that would be an appropriate health message. There are so many parts that fall under grey areas.

It's not the intent that we'd do this on the signs in retail establishments. What there might be on that sign, though, could be like the example I used yesterday, "For those of you who are addicted"—or however you word it—"here's a 1-800 line that you can call," or "If you were to buy a pack a day, you could afford to buy a good GM car or something by the time you reach"—

**Mrs Caplan:** I think Mrs O'Neill may be concerned that what you're planning to do is insist they put Bob Rae's phone number on the cigarette package.

**Mrs O'Neill:** Smokey the Bear has done a good job preventing forest fires. We don't need it on packages. Jeez Murphy.

**The Vice-Chair:** Any further speakers? If not, you've heard Mr O'Connor's motion to amend section 6. All in favour? Opposed? Carried.

All in favour of section 6 as amended? Opposed? Carried.

Section 7: The first is a PC motion to amend subsection 7(2.1).

**Mr Jim Wilson:** I move that subsection 7(3) of the bill be amended by striking out "months" in the second line and substituting "years."

The effect of this amendment would be to give a three-year time frame for the phasing out of the sale of tobacco products through vending machines. We had some owners and vending machine operators appear before us, one in particular I remember from Orillia who services my area

of the province in Simcoe county and beyond. Their sole product line was cigarette vending machines, a family-operated business.

I hope members will recall that the request was, if you're going to ban vending machines, if you're going to go beyond what the federal government has done, which is simply to restrict it to bars and licensed establishments, if you're going to go all the way and ban cigarette machines that sell tobacco products, they need as long a period of time as possible to adjust.

1430

This particular company that I have in mind testified before this committee that indeed they had a great deal of their personal finances and the house and family members' houses tied up in this business. They pleaded with us to give them a three-year time frame, and I think it's only appropriate. The government's time frame is too short to be fair to these business people who, through no fault of their own, are currently selling a legal product through a legal means, and that is a vending machine.

If you're going to change the rules, I just plead that you make this phase-in of this new law as compassionate as possible for these people you are going to put out of business and give them an opportunity to convert their business into something else. That takes time. It takes time to make those arrangements with your bank. I think banks would look more favourably on this particular family business and others that appeared before this committee if they knew there was a three-year time limit or thereabouts to make the adjustment.

**Mr O'Connor:** I appreciate hearing this view from my colleague. You'll note, for committee members, that there is a government amendment that will be coming up. It's consistent with the time frame that would deal with other areas that would be subject to the legislation.

We did hear from individuals saying that we didn't want to be in a situation where the federal government implemented a total ban on vending machines right across the province, everywhere with the exception of licensed premises; that we want to go beyond that and we have to go beyond that, because these places aren't restrictive to young people. Young people can go in there. We heard from young people before this committee who said that they have that accessibility. That's why we need to move with this amendment.

After listening to the people who made the presentations, we've actually extended it beyond the three months and given them a time frame which they can work towards, not a date that's somewhere in the future and a year beyond but a date that's pretty clear, December 31, that I believe will give them something to work towards. I think it's been done in a spirit of fairness, as was requested by the people coming to this committee.

**Mr Jim Wilson:** The people coming to this committee who made that request don't run these operations right now. There must be some compassion for people who are in a legal business right now and you're changing the rules. December 31, which is your new amendment, is actually not much of an extension beyond the three months in the current section.



Given what I said yesterday, that your December 31 time line may sound great to you but it doesn't make a hell of a lot of sense to the business community, would the parliamentary assistant be willing to consider a compromise? Maybe three years, my amendment, is a bit too long for people to be comfortable with from the health promotion side. Would you consider two years if I were to amend my amendment?

**Mr O'Connor:** I see you've got two amendments here. One is for one year?

**Mr Jim Wilson:** The one we're dealing with right now is three years, replacing three months.

**Mr O'Connor:** Okay. I hear where he's coming from.

**Mr Jim Wilson:** But you don't care.

**Mr O'Connor:** Two governments ago in Ottawa they decided that there was going to be a total ban on vending machines everywhere but the exemption and never gave them a date to work towards or to lay out a business plan or to decide. The present government enacted that legislation, and it does cause some difficulties.

We're trying to put in an element of compassion that was asked of this committee and we're going to keep it consistent with the other parts of the bill. December 31 will give them an extended period of time. Knowing that the reason we have this here before us is that young people have access to these machines, whether they are ones that are in non-compliance to date with the federal legislation or ones that could be in compliance if they were where they are supposed to be, they are still accessible to young people, and the key here is that we're trying to deal with an issue and recognize the business needs of these people and put a little bit of fairness in there.

**Mr McGuinty:** I want to speak in favour of the motion. I think the good news here—at least put this on the record at first—is that the government has acknowledged that there's a problem telling these people who've been running these businesses, which are quite legitimate, that we are pulling the rug out from under their feet.

It's one thing to argue that the pharmacists sought intervention and were aware that there was something coming down the pipe, but no such argument can be made on behalf of the vending machine people. They did not understand at any time, until very recently, that they were going to be put out of business and they wouldn't be allowed at all to use those machines.

Let's recognize as well what it is we're talking about here, again keeping in mind the focus of the bill is to make it harder for young people in the province to start smoking. What we're talking about is extending the time period during which people can continue to operate, but they'll be governed by the existing federal legislation.

That federal legislation says you can't have a vending machine anywhere unless it's in what they call a beverage place, and if you look at the federal regulations, that says you've got to generate 80% of the money you make there through the sale of alcoholic beverages. You're talking about bars and taverns and things of that nature. You're not talking about family restaurants. If there are kids inside those bars and taverns, then that's not an issue

we should be attempting to address through Bill 119. That's another problem which can be addressed in other ways.

**Mr O'Connor:** But they're legally there.

**Mr McGuinty:** Well, I just don't know many kids who go to bars and taverns.

**Mr O'Connor:** A licensed family restaurant, though, is—

**Mr McGuinty:** No, no, no. With respect, Mr Parliamentary Assistant, you're mistaken: 80% of the sales have to be generated by the sale of alcoholic beverages. So that rules out family restaurants. We're talking bars and taverns, and I just don't see many kids inside those bars and taverns.

I would like to see us not deal with vending machines at all and just allow the federal regulations to be in place. It removes them from hotel lobbies. It removes them from all those kinds of places where they're going to be in an unsupervised location and just simply confines them to bars and taverns.

However, the government is bent on phasing them out completely. The good news is that you've acknowledged it's going to be too harsh to do it in three months. I think that economically it would be much more humane to allow these people to have a much greater time frame to do that, and three years is hardly extremist, again keeping in mind that during that period of time, kids will not be inside—at least they shouldn't be inside—bars and taverns.

**The Vice-Chair:** Thank you. Mr Wilson.

**Mr Jim Wilson:** Oh, Mr Wilson?

**The Vice-Chair:** Yes. I had your name down. Do you want to go now?

**Mr Jim Wilson:** Yes. I think Mr Sterling wants to go first, though.

**Mr Sterling:** You know, I don't understand the government on this one, and I agree with Mr McGuinty on it, in that earlier we heard the parliamentary assistant say, "We're not going to do plain packaging now because we want a national consensus on this." The federal government has taken steps to deal with vending machines. They've limited vending machines for the sale of cigarettes to basically bars and grills where 80% of their sales are in spirits.

On the one hand, Mr Parliamentary Assistant, you're saying you want a national consensus. Surely to God, the idea of protecting young children, young people, who cannot be in these bars and grills until they're 19, the same age as in this act in terms of sales—what is your objection to the federal regulation on this?

You want national consensus on the one hand. That's your excuse for not doing anything here and taking leadership on the matter right now, next week, on plain packaging. Yet we have a national consensus, effectively, by the federal government saying it's going to ban cigarette vending machines in most places. What's your problem?

1440

**Mr O'Connor:** When the federal government was

drafting its legislation it did take a look at Ontario as an exception in this case because our licensed premises are open to children. A family restaurant is licensed premises.

**Mr Sterling:** But it's been pointed out that a family restaurant would not qualify under the federal regulation. So don't mislead the committee that way.

**Mr O'Connor:** I wouldn't want Mr Sterling to mislead anyone either in this. In Ontario they aren't licensed separately, so don't make that argument, because it doesn't work. What we've got here is something that was pointed out to the committee, that they're not licensed separately under the liquor licence board here in the province of Ontario. So these premises have the ability for people to go in there who are under the age of 19, and that is a conundrum that the federal government faced. I'm sure they were well aware that we would have to be dealing with that ourselves here.

The health communities came before this committee and pointed out that it's a real problem. It's a situation that sets us apart from the rest of the country. I think that the point here is that we are an exception and it's time that we did move forward on this issue. We are different than other jurisdictions in the Confederation of Canada.

**Mr Sterling:** I have a second question for the parliamentary assistant. I'm quite willing to accept a December 31 close-off date if he's willing to show his generosity, or the generosity of his government, which is going to throw these people out of business, by accepting my amendment to compensate these people for their machines, which they have purchased with the mortgages of their homes. Are you willing to support the amendment which I'm putting forward to fairly compensate these small business people for the amount of money that they've put out for these machines?

You want to cut them off. It's like throwing a person out of his mortgaged home or all of his assets. You want to cut them off on December 31. Out of the big heart of your government you want to extend it from three months. "We're not going to throw you out of your house and home in three months. We're going to throw you out of your house and home on December 31." Boy, that's big-hearted.

I will agree with you: Throw them out in three months, but will you compensate them for their investment, their life savings that they've put into this legal business until you're cutting it off now? Will you compensate them? Will you accept my amendment?

**Mr O'Connor:** It certainly is interesting to hear that come forward as an amendment from the Conservative Party. When I talked about the federal legislation in dealing with this issue because it's an issue that the health community brought forward as an access point for young people to these machines, when the federal Conservative government of the day was drafting its legislation, knowing full well that when it put in place a ban right across the country, everywhere but licensed premises, it didn't talk about a compensation package. When the government of the day proclaimed that legislation it put some ads in the newspapers but it never talked about a compensation package.

Here's an opportunity, when we see the opposition members come and say, "Let's just spend a little bit more money because it's the right thing to do." We're coming up with something better than what Ottawa's done. We've given them a date. We've given them something to plan towards. We've given them a date where they can see that they are going to have to shut down their business.

The fact is that the Conservative government never had that date for them. The Liberal government didn't and it took out ads after the fact. The hearings are taking place. We heard from people. People came forward to this committee asking for some extra time and we're giving them some extra time.

**Mr Sterling:** Listen, the federal Conservative government got two seats in the last federal election. I'm not following their lead, Mr Parliamentary Assistant. You're talking to a guy who's fought for controls in terms of dealing with tobacco for the last eight years. I want fairness for the people of Ontario when we change the rules.

I'm not talking about the federal Conservatives, whatever those fat cats were, in your terms. I'm talking about the poor devils who've invested their life savings in this legal business and you're going to confiscate them. You're going to put them out of business. We are going to put them out of business. We are collectively going to put them out of business. I'm talking about fairness, equity.

When somebody's fired from their job, they get severance pay, they go on unemployment. These people don't. When they lose their business, they lose all. Will you compensate these people when you take away their business, when there's no longer any use for their machines? Will you compensate them? I've put forward an amendment, Mr Parliamentary Assistant. Do you have compassion for these people? Will they be compensated by our government, fairly compensated? Will they be?

**The Vice-Chair:** Do you wish to respond?

**Mr O'Connor:** I responded to the case. The fact of the matter is, we're giving them something far greater than other jurisdictions have given them. We're giving them a date to plan towards. We're giving them a date that they can see. It's December 31, 1994. They've asked for an extension in time and they've been given that extension in time. We haven't seen people at other levels who have been dealing with this issue suggesting compensation.

**Mr Sterling:** Nobody's banned them before, sir. They haven't banned them at the federal level. They have not banned them at the federal level.

**Mr O'Connor:** A total ban.

**Mr Sterling:** They have not.

**Mr O'Connor:** Except for—

**Mr Sterling:** Except for—

**Mr Jim Wilson:** Which was acceptable to the industry. It was negotiated with the industry.

**The Vice-Chair:** One speaker at a time. Did you finish your response?



**Mr O'Connor:** Yes.

**Mr Jim Wilson:** That was the most heartless response I have ever heard from a government parliamentary assistant. Honest to God, my blood is boiling over here. You're going to put people out of business. You're not willing to consider—they asked for three things from this committee and you won't budge on any of them.

They wanted more time than was being considered, either in the original bill or by your December 31 date. They agreed that: "Okay, if you're going to put us out of business, at least compensate us. That would be the fair and humane thing to do because you're unilaterally changing the rules and we're selling a legal product by a legal means now."

Otherwise, you're saying retroactively, "They're crooks," and you're out to confiscate their goods and not compensate for it. It's certainly morally wrong; there's got to be something in the law to make that wrong, that governments could come in and take away your livelihood and your house and everything you've put on the line just by a simple wave of the pen. That's sick, that's absolutely sick.

The federal government did not do that. They negotiated with the industry. You had witnesses here saying, "Actually, they sat down with us and we agreed with them that vending machines that sell tobacco products should be in bars and taverns." That's what they did. That was their third option.

Now I have an amendment to do that, to move it into licensed establishments and I am assuming, because you have spoken against it, that you're not going to accept that. What are you going to do for vending machine operators?

**Mr O'Connor:** The fact here is, let's take a look at maybe a jurisdiction. In this country, Canada, Nova Scotia, you know, part of the Confederation, went with a ban in all public places of vending machines and they never had a compensation package in there. We heard from people coming from that industry who said, "We need to have some time," and so we're going to extend that time to December 31 of this year, most likely more than doubling the time that they had. We've listened; we've been far more compassionate than what we've seen in other jurisdictions—

**Mr Sterling:** You're not going to throw them out of their homes until it's cold in the winter.

**Mr O'Connor:** —where the total ban, with their exception, put them completely out of business.

**Mr Sterling:** The sum total of your compassion towards these people is that you're not going to drive them out of business, drive them out of their homes, drive them out of their lifelong investment in three months. You're going to do it for the new year, on December 31. Is that the extent of your compassion and consideration for these small businesses?

What have you got against small business people? What have you got against people who invest their life savings and go out there and try to make it on their own? What have you got against them?

**Mr O'Connor:** I guess this is where we end up with

a little bit of rhetoric. What would the Conservative Party have against small businesses when it implements things like free trade? What would they have against small businesses when they go with high dollar policies, high interest rate policies, for extended periods of time? What do you have against small business? We had people come to the committee; they asked for some more time and we've giving them some more time.

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**Mr Jim Wilson:** On that note, are you really giving them more time? The way this section is worded, you have no idea at this point when this section will come into effect. You don't know when this bill's going to pass. Three months may turn out to be more time than your December 31 arbitrarily chosen date, because you think it's a nice, neat date.

**Mr O'Connor:** Unless the opposition filibusters and holds this up for some reason and doesn't allow us to have it proclaimed in the spring session.

**Mr Sterling:** You're giving us more and more reason.

**Mr Jim Wilson:** You're giving us more and more reason to be ticked off at you about this legislation. I want you to answer the question. I don't want to hear any more comments about what other jurisdictions are doing. I want to know why your government is so against small business in this province. Why? Why? Why? Answer that question before we go any further. Why no compassion at all for these people?

*Interjection.*

**Mr Jim Wilson:** This is a business, this particular one.

**Mr O'Connor:** We've seen far more compassion for small business from this government. We've seen this government actually roll back taxes for small business people. We've seen far more compassion for small business from this government than we have in many years from other governments.

**Mr Sterling:** That's why they're all leaving.

**Mr Jim Wilson:** Oh, they really believe that. I get that on the street all the time.

**Mr O'Connor:** People came to this committee asking for some compassion, asking for an extended period of time so that they had an opportunity to lay out a business plan that would allow them to move on. Other jurisdictions never had the same compassion to lay down a date.

The Tory government in Ottawa didn't lay down a date. When it was enacted by the government of the day in Ottawa, it didn't say a date. They proclaimed it, and the people who represent these small businesses thought they had till July 1, thought they had a little bit of time to go. That's not the case. They never had that opportunity. Next thing you know, after it was proclaimed, the ads show up in a newspaper: It's time to get them out.

What we're doing here is we're actually giving them a date, something that they can plan around so that these small business people have something to plan around. I think that's far more generous than what we've seen from some Conservative governments.

**The Vice-Chair:** Any further speakers? If not, you've

heard Mr Wilson's motion to amend subsection 7(3). All in favour of the amendment?

**Mr Jim Wilson:** Could I have a recorded vote?

**The Vice-Chair:** A recorded vote.

**Ayes**

Sterling, Wilson (Simcoe West).

**The Vice-Chair:** Opposed?

**Nays**

Abel, Caplan, Carter, Frankford, Haslam, O'Connor, O'Neill (Ottawa-Rideau), Rizzo.

**The Vice-Chair:** Motion lost.

Mr Wilson, you have a second motion?

**Mr Jim Wilson:** I move that section 7 be amended by adding the following subsection:

"Exception, licensed establishments

"(2.1) Despite subsection (1), a person may permit a vending machine for selling or dispensing tobacco to be in premises to which a liquor sales licence under the Liquor Licence Act applies."

This is another attempt to show some understanding to the vending machine industry. The federal act did limit vending machines that dispense tobacco products to liquor establishments. While the argument is made that in Ontario the effect of the federal law and the effect of this amendment would be that licensed family restaurants would still be able to have cigarette vending machines, the fact of the matter is, I think, the very fact that we give these people a licence to distribute a controlled product like tobacco means we should also trust them to supervise the vending machine, and we certainly could make regulatory authority for that. I know that other jurisdictions have done that, including the federal government.

Again, we've seen this government. There's no compensation for these people, like the family business in Orillia that will go out of business, along with every penny they've ever saved. A number of the family members and relatives and friends are employees of that business. They just don't care. They really just don't care. We hear Mr Sterling's amendment for compensation. They won't allow a reasonable period of time so that these people can get their business affairs and family affairs in order.

I'm hoping they'll accept this amendment so that, like the federal government which came up with an agreement with the vending machine operators that was acceptable, this government would not look for cheap political hits by trying to outdo the federal act by saying, "We're going to ban vending machines totally"—we heard about national consensus before—but move them and restrict them to simply licensed establishments.

**Mr O'Connor:** The government won't be supporting this. In fact, if we take a look at this motion that's before us, it's even more open-ended than the federal government's legislation. This is exactly the reason I was saying that family licensed restaurants are open to young people to have the access to go in and purchase the cigarettes. This is actually far more open than even the government in Ottawa had intended. For that reason, trying to deal

with the access by minors, the government won't be supporting this.

**Mr Jim Wilson:** Again, I asked legislative counsel to give me an amendment that would conform with the federal act, and this is what they came up with. It was the opinion of legislative counsel at that time that this did conform to the federal act and was not more open. I am quite willing to introduce any amendments the parliamentary assistant might suggest—I'm willing to stand it down if he's willing to be reasonable about it—that would give him a greater comfort level and his party a greater comfort level with this amendment if your only problem seems to be that it goes beyond the intent of the federal act.

**Mr O'Connor:** The point is that this doesn't even meet with the bare minimums of the intent of the federal act. We heard people come to this committee and make presentations that stated that their concern is that a family restaurant, which is a licensed premises under the Liquor Licence Act, would then have access. This doesn't even go as far as the intention of the federal legislation. The fact is that what we're trying to deal with here is the access by minors. For those reasons, I can't support this amendment, though I realize its intent.

**Mr Jim Wilson:** Let me just finish commenting on that, though. You're in a family restaurant. There are lots of adults around. There are liquor servers, and there's usually a bartender or someone who actually is in charge of upholding the Liquor Licence Act that's granted to that premises. You've got more control there. I thought the real problem was, for instance, when we were at the hotel in London, Ontario, where there was a vending machine at the end of the hallway with nobody around; it was next to the washrooms. I agree that's a problem.

Why can't we put this into controlled premises? That's what this does, because you'll get the control you want. You'll get the control while allowing vending machine operators to stay in business for a while and allowing people who like to smoke in a bar to have access, those who are legally able to do so under this law. I don't see any problem with this.

I thought we had testimony that a very small percentage of cigarette sales are going through vending machines now and that what your government should be doing, which we agree with, is just restricting that access to a sensible level, which is to move it into licensed establishments, like the federal act.

**Mr O'Connor:** The difficulty we have is that the federal government, in its wish to contain the sales to the more restrictive of licensed premises—we don't have that more restrictive designation in the province, so we don't have a way of going in there and saying which is the more restrictive and which isn't. Family restaurants are licensed under the Liquor Licence Act, so we have some difficulty there.

To clarify a little further with some legal opinion, I ask our legal counsel, Frank Williams, to continue a little and explain some of the differences we do have and the difficulties with the Liquor Licence Act.



**Mr Williams:** Perhaps I can put a historic perspective on this just to give you an understanding of why the federal legislation is crafted the way it is and why we have the problem in Ontario that we do.

Before I think 1988 or 1989, the Liquor Licence Act in Ontario licensed bars, taverns—there were different designations of licensed premises. For certain of those licensed premises, persons under the age of majority were not allowed into those premises. When the act was amended in the late 1980s, the act was changed to talk about licensed premises in a general way.

There were no designations of bars or taverns or public houses, another common designation.

Before 1989, part of the requirement under the Liquor Licence Act regulations at that time was that to get that type of designation you had to have a certain ratio of liquor to food sales. We don't have that any more in Ontario, so it's a very big difficulty in how you would differentiate, even in Ontario, what a tavern or a bar is, using the definitions in the federal statute.

The problem we have, basically, is with that all licensed premises in Ontario, other than a handful, according to my understanding, anybody can go into those premises. They can't be served liquor if they're under 19, but they can go into those premises. There is a handful of premises, I've been told by the Liquor Licence Board of Ontario, where there have been problems of sales to young persons, and they have a restrictive clause in the licence whereby they can't even admit young people to those premises. I've been led to believe there is a handful of those premises in the province.

The problem is that it's not a just matter of family restaurants. Young people can go into what we would think of in the old days as bars and taverns, public houses.

**Mr Sterling:** When we're making these laws dealing with smoking, you always have to check back on whether the political rhetoric becomes greater than what you're doing in the end. I see us penalizing a small group of people who have invested, in some cases, their life savings in buying these vending machines and setting them up in various places.

While what legislative counsel has said may be true, according to the federal regulation, as Mr McGuinty has shown it to me, it is clear that you can only have these vending machines if 80% of the gross sales are in spirits. If the government wants to put in an amendment to this bill and say it's up to the owner of that particular establishment to show that 80% of its sales are in spirits in order to have a vending machine, fine and dandy. If he wants to go further and restrict young people from going into that particular venue, fine and dandy.

I don't think many children go into bars where 80% of the sales are spirits. Sure, children go into the Swiss Chalet or family restaurants where a small percentage of the gross would be alcohol sales, and that's probably only some of those restaurants where they have alcohol. But we're not talking about that here. We're talking about bars where cigarettes could be sold this way. I don't think that's an unreasonable compromise when we're

talking about the other side of the issue. The other side of the issue is, do we throw these people completely out of business? This government has indicated that when it's going to throw them out of business, it's not going to compensate them or deal with the redundant machines these people are going to be left with.

You've got to balance rights in here and you've got to think about, how much of a danger is it that a package of cigarettes is going to be sold in one of these kinds of bars to an underage person? I think the risk is minimal, very, very low, if at all. When you weigh that against the ability of a young person to obtain tobacco by other methods, the risk of getting it through a vending machine in these kinds of places is much lower than that a young person could get it off the street by asking a friend or an adult to go in and buy the cigarettes for them. I think the risk is much greater on the other part, getting somebody else to go in and buy them for them. I think that's going to happen regardless of the laws we make here in Ontario.

This government is being really heavy-handed. If I were one of these people who owned and had my life savings in this, I'd say the intent of the government is mean-spirited and it's to throw me out of business. That's the way I would view it. You've got to deal with that. These people are Ontario citizens.

I thought governments had to act reasonably in this regard. You wouldn't dream of saying to workers, if somebody goes bankrupt and goes out of business, "You're not entitled to any benefits." You wouldn't do that. You wouldn't say, "All the employer has to do is give an eight-month notice and then you're out of work, no benefits, no severance pay." You wouldn't do that, would you, Mr O'Connor?

**Mr O'Connor:** If we're responding to hypothetical questions, I could throw out another hypothetical question: Are you suggesting that we create a new department within—

**Mr Sterling:** You're the government, Mr O'Connor. You're defending this legislation.

**Mr O'Connor:** Are we about to create another department within the Ontario Liquor Licence Board so it can differentiate and give separate licences, so we can duplicate what we have in licensing through the Liquor Licence Act to comply with this? The key here is that we heard presentations come to this committee, and we've got 13,000 people in the province who die prematurely every year from tobacco-related illnesses. That represents about 100 people in a riding every year who are dying from tobacco-related illnesses.

**Mr Sterling:** You're going to take it out on vending operators. It's the vending machine operators' fault.

**Mr O'Connor:** Do we turn around and ignore the evidence presented to us?

Are we suggesting at this point that we create more bureaucracy to further regulate small businesses? I don't think we need to further regulate small businesses. What we need to do is lay out a date, give them a time to plan towards and go forward with that, not create more departments within the government to go and put in

further restrictions for people through liquor licensing changes. I don't think that would be a responsible way of doing it, and I don't think the way the federal government is doing it is responsible. They said, "Vending machines are banned right across the country whenever we decide to proclaim the act, with the exception of these licensed premises." We're giving them a date, and they came to us asking for an extension in time and we're giving them an extension in time.

**Mr McGuinty:** I can't support this particular Conservative motion for a couple of reasons. Number one, it's in conflict with the federal legislation. I understand that wasn't my colleague's intent, but I see it as being in conflict with existing federal legislation.

The other problem, having canvassed this issue with people in the business, is that I don't feel they can adequately deal with access of young people to cigarette vending machines in places other than bars or taverns. The best amendment, and I would have moved it myself had I felt there was a chance of it meeting with some success, would be to simply remove vending machines entirely from the ambit of Bill 119, because they are presently regulated by federal legislation which confines them to bars, taverns or other similar beverage rooms, to quote from the regulations.

It's important to keep in mind as well that there's another requirement in here. Under the federal regulations, it says: "The person in charge must be able to directly monitor the vending machine during normal operating hours." Second, "A vending machine has to be situated at a distance of not more than five metres from the innermost part of any entrance to the designated area." They have gone to some lengths, and I would submit those are very reasonable lengths, to restrict access by young people to cigarette vending machines.

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Remember again, the focus of the bill, and the area in which we always have consensus, is to make it harder for young people to start smoking. Whenever we stray from that, we get into hot water, we get into trouble.

Mr Sterling makes a good point. The risk element associated with kids getting cigarettes from bars or taverns is minimal, absolutely minimal, and I think the only thing we are going to succeed in doing is alienating a group of people unnecessarily who will be ticked off with big government intruding into their business affairs. I think they are all prepared to buy into this argument that kids are getting cigarettes from vending machines and are prepared to give up that part of the business that's not found in bars and taverns. I recall, when we had a group of young people here, two of them saying they got their cigarettes inside a bar. The risk element is so minimal that it simply doesn't warrant us going ahead and saying cigarette vending machines will be banned outright in the province.

The other argument, of course, and somebody made it earlier, is that if we're going to proceed with plain packaging, the ideal is that rather than on an ad hoc basis, we'd like to be able to do that on a national level. Well, the feds have already done it with respect to vending machines.

**Mr O'Connor:** Nova Scotia went further.

**Mr McGuinty:** Nova Scotia may have gone further, but we're not in Nova Scotia; we're in Ontario. I think the feds have done all that can reasonably be done to eliminate access by young people to vending machines in the province and across the country.

**Mrs Haslam:** I'd like to comment on a couple of the things that have been brought forward, the talk about access to bars. I know for a fact that there are underage people who get into the bars. They may not be served liquor but they do get in and they do go with friends, and if they're caught and they're not given liquor, they still have access to that vending machine. They may not be 12, but there are 16-year-olds who do get into those licensed facilities with friends or with an older person, and as a result of being within that facility they would have access to the vending machines.

When you say "minimal," it may be minimal but it is not impossible. I think we should err on the side of young people and say we should not have them available. I don't care if it's one person or two persons—

**Mr Sterling:** Even if it throws 10 people out of business and they lose their—

**Mr O'Connor:** Thirty thousand lives.

**Mrs Haslam:** I don't care if it's one person or two persons. If we can limit the access—

**Mr Sterling:** So that's worth it, eh?

**Mrs Haslam:** If we could actually limit the access of cigarettes to young people, that's what we should be looking at. And that's what this is about: limiting access to cigarettes by young people. They do come into contact with those vending machines.

**Mr Sterling:** You are a mean-spirited bunch.

**The Vice-Chair:** Please, one speaker at a time. Mrs Haslam has the floor.

**Mrs Haslam:** I'm concerned about compensation programs for businesses. What would happen if, because of the limit on moose tags, we had a person who works in a camp come in and say, "Because of that, my business is suffering and I'm demanding a compensation package." We would open the doors to many compensation packages, and at a time when your leader is saying, "Don't spend extra money." Mean-spirited? I would call him mean-spirited when he says: "Don't spend extra money. We should cut back on lots of programs." And you come here and say we should put out more money for a particular area, and we just don't have the money to put that kind of compensation package in place.

We have the leader of your party saying cutbacks, that we should slash more, not open up new projects, not open up new programs: "Don't put new money out there in the community, don't put new money into the social net, don't put any new spending in place," and you're here saying, "We want you to put more money into this particular issue."

When you say mean-spirited, in other jurisdictions where this was brought into place, the federal government wasn't looked upon as being mean-spirited. They were doing a job which we all have to do now. We should do



our job now and get on with looking at this particular piece of legislation, looking at protection for our young people. That's what it's about.

**Mr Jim Wilson:** We've got to get rid of this mythology that somehow the federal government has brought in a total ban. They haven't. We were told in this committee by vending machine operators, who I trust know their business better than anybody else in this room, that it was acceptable to them that the federal act restricts their machines to bars and taverns, licensed establishments like that, because that's where the business is. It's a convenience factor for those customers who like to have a cigarette with their drink at those establishments.

In fact, we were told it was not worth their while to put it into family restaurants. One person defied us to find a number of locations in the province. He said it was insignificant. If you wanted them moved out of family restaurants, there was no complaint from any of the witnesses about that. They didn't have any problem with that at all. They said it's not profitable to put them in there anyway, and fine. The federal government went through all these arguments with the industry and that's why they came up with what they did.

I want to ask legislative counsel two questions. When you go to a bar here in Toronto or anywhere else, if you go to a club, for example, your ID is checked at the door. Why do they do that, and is that unconstitutional? Are they not allowed to do that or not supposed to be doing that? It's always checked at the door at the clubs in Toronto here—that's why there are huge lineups—and that's before you're served a drink at all. I want to know why that's done, and if it's unconstitutional, I guess they'd better stop doing it. By the sound of it here, that shouldn't be done, with some of the arguments made earlier that there's no control in these establishments. You have to show picture ID, which is required by law, the age of majority card.

The intent of my legislation is to not close the doors on vending machines totally. It's to move it into the licensed establishments. If that were the case in Ontario, if we didn't close the door totally, would not the federal act then supersede this act? I can see if we do a complete prohibition in Ontario the federal act is null, but if we leave the door open a bit, would not the federal act then be the law of the land?

**Ms Filion:** I'm afraid, Mr Wilson, I'm not in a very good position to answer your questions. I'm here as counsel to answer any questions relating to the drafting. I'm not an expert on constitutional matters and I'm not an expert on the federal legislation either, so I'm afraid I can't answer your questions.

**Mr Jim Wilson:** Perhaps Mr Williams could take a stab at it.

**Mr Williams:** I must admit I'm not a constitutional expert either, but to the best of my knowledge—I assume your question is, is it constitutional to ask somebody for ID?

**Mr Jim Wilson:** From the discussion we had, there is restricted access to bars in Ontario. You can't get into a club in Toronto unless you show you're 19 years of age

or over. How are they doing that if there's no law?

**Mr Williams:** No, no. I think you're mixing—when you're asked for ID when you're going—

*Interjections.*

**Mr Jim Wilson:** Not for clubs, not for the vast majority of them. I'm just wondering how they get away with that if there's no requirement to do that. These people aren't drinking; they're being asked for their ID as they line up.

**Mr Williams:** I'm going to answer your question. The question is, I assume, why are you asked for ID? I think you're asked for ID so that the owner of the establishment knows whether they can serve you liquor, but you're still permitted access to that premises despite the fact that—

**Mr Jim Wilson:** No, you're not. The Metro police charge you if you have people in those premises—

**Mr Williams:** I beg to differ with you. The Liquor Licence Act does not restrict entrance to a licensed premises to somebody who's under 19 years of age. You can enter the premises, but you can't drink on those premises.

**Mr Jim Wilson:** But that's not the practice. They refuse entrance.

**Mr Williams:** You asked me my opinion, and you asked me what the law is, and that's what the law is.

**Mr Jim Wilson:** So they're doing it, but they have no law to back them up. So the next time I get complaints from my constituents that they couldn't get into one, I'll say, "You have an absolute right to be in that premises."

1520

**Mr Williams:** As I said earlier, there are, as I understand it, approximately a half a dozen licensed premises that have terms and conditions attached to their licence whereby they're not allowed to permit young persons under the age of 19 into those premises because in the past they have been charged with serving to minors, but the majority is—

**Mr Jim Wilson:** But the rule for nightclubs in Toronto may or in my riding, in the hotel in Collingwood, the one in Alliston, is to ask for ID at the door.

**Mrs Caplan:** They maybe need one of those for the restricted licence.

**Mr Jim Wilson:** They can't all be restricted. He says there are only half a dozen in the province. So there's no law for this.

**Mr Williams:** Let's not confuse the fact that a young person may or may not get into a type of premises, for example, where there is nudity. That might be a municipal bylaw that restricts that.

**Mr Jim Wilson:** There's nothing to do with nudity at the Big Bop or RPM or the bars in Collingwood or all the ones in my riding. This is a standard practice.

*Interjections.*

**Mr Jim Wilson:** You people get with it. How the heck do you know what's going on in the province if you don't go out once in a while, for goodness' sake.

**Mrs Haslam:** Get with it, Jim. There are 16-year-olds

in the bars. They just can't be served.

**Mr Jim Wilson:** So basically they have no legal means of doing this. They're just doing it as a matter of policy for their clubs.

**Mr Williams:** As I say, I don't know what the restrictions are because of municipal bylaws, but certainly under the Liquor Licence Act there's no restriction.

**Mr Jim Wilson:** What about the question about the federal legislation?

**Mr Williams:** I can't comment on that. I'm not an expert on the federal legislation.

**Mr Jim Wilson:** Can we get an answer to that? That would be important, because the parliamentary assistant's premise is that this isn't consistent with the federal act. This to me leaves the door open for the federal act to take effect in Ontario.

**Mr O'Connor:** Are you suggesting that we put in a dual licensing system so we can put in a licensing system that complies with the intent of the federal legislation? We're talking about creating another licensing system for those licensed establishments.

**Mr Jim Wilson:** You've got a federal law that the people of Canada right across this country are entitled to be ruled under, and you are nullifying that law for no particularly great reason, as far as I can tell. Canadian citizens have a right to be served under Canadian law of the Canadian Parliament. You'd better have a darned good reason for nullifying that law. I'm trying to leave the door open so that the law of this country can be applied equally across the country—

**Mr O'Connor:** We know you're trying to leave the door open. That's what the health community was telling you.

**Mr Jim Wilson:** —so the people of Ontario have access to the law of this country so that you socialist nuts aren't running amok. I think it's a good federal law, and the people of this province—

**Mrs Haslam:** You'd rather have fascists running it?

**Mr Jim Wilson:** —are entitled to be citizens under that law and not under your social experimentation all the time.

**Mrs Haslam:** Or fascist laws.

**Mr Jim Wilson:** You said it, not me.

**Mr O'Connor:** The difficulty we have here, one of these areas where we run into differences of opinion, is that I don't think the government is ready to move forward with a separate licensing system that would allow us to comply with the federal legislation. The only practical way I could see of identifying establishments from what we have under the Liquor Licence Act right now would be to set up a new licensing system that would comply with the federal regulations.

What we have here is something that's a response to the people from many parts of the province who came before us and said that given that Ontario is the exception when it comes to liquor licensing, given that young people have the legal ability to go into these licensed premises, they also have the ability to put their coins into the vending machine without that vending machine

saying, "Excuse me, but are you 19 years of age?" That's what it comes down to. The vending machine doesn't have that ability, and we know this is another source for young people to get this tobacco product. We've got 13,000 people in the province dying every year from tobacco-related illnesses, and we need to move forward. Let's recognize that this is an access point young people have, and that's why people made that presentation to us.

**Mr McGuinty:** To go back for a moment to Mr Wilson's query, which I think was very legitimate, about the law in the province with respect to young people gaining access to bars and taverns, it's my understanding that people who operate these premises, as a matter of policy—at least some of them; I'm not sure how widespread the practice is—for purposes of their own protection, rather than having their waiters or waitresses ask prior to serving a patron each time, screen them at the door. Their policy is: "If you're not above the age, you're not getting in, period. I don't want to have to deal with you inside and have to worry about whether I'm serving people who are under age."

It would be very helpful to know how many bars and taverns have that kind of policy in place. Certainly in Ottawa and Hull, I believe that to be the practice. Perhaps in smaller communities where there are not as many people going to these places and on a busy night it's only one third full or something, they're not going to be that selective, but in busy places like Ottawa and Hull certainly that's the practice.

The other problem I wanted to remind the committee members about was one that was raised by a couple of presenters, I believe. What we're telling the people who run these establishments now is that they're going to get into the cigarette sales business. They don't want to be in the cigarette sales business, but if they don't sell cigarettes over the counter now, they feel they're not going to be able to hang on to their clientele.

We've got a lot of people in this province who have grown up, unfortunately, with cigarettes. When they go out for a drink after working all week, paying their taxes, perhaps changing a few diapers and cutting the grass and reading the paper along the way, doing those things that people normally do, they want to have a cigarette with their drink. Now, that's not the kind of activity I condone or encourage or that I would engage in myself, but it's not illegal. We have allowed it to go on and it will go on for many, many years to come.

What we're telling these people in those establishments, particularly the smaller ones, where they're not going to sell cigarettes, is, "If you run out of cigarettes that night, go elsewhere," if they're not going to sell them there at the bar. You know, it's not unreasonable, it's not unforeseeable that you might have somebody going elsewhere after drinking in order to get cigarettes because, as we know, they have an addiction. They have an actual, real, physical craving for a nicotine hit and they're going to want to get that. It's just another example, if you follow this through, of the kinds of problems you get into, and I think it's all for naught.

**Mr O'Connor:** I appreciate what he's saying. He's made some interesting points. The most compelling



argument he's given me is the fact that there are some premises where they don't want to take that chance of being in a situation where they may be selling to a minor. They don't put something where they walk by and you have to put a little mark on a chalkboard as you go by that, "Yep, I'm 19." They actually have a person ask them whether they're 19. The vending machine doesn't have the capability of having that physical contact to ask the person whether they're 19.

I would suggest with regard to the argument he's using that it's good business practice people have to ask people whether they are 19 years of age. The same rationale could be used that the vending machine doesn't have that ability to ask a person. The difficulty we have would be creating a full new department within the liquor licence board to deal with a separate licensing element for those who want to have the vending machines in these establishments. I think it would be irresponsible to create more government at a time when I'm not getting too many calls saying, "Let's create some more government."

There are some problems here and obviously there are some differences of opinion, as we've heard on many different issues. For us to walk away from what is a difficult issue—and no doubt when the other government was making its legislation, it probably looked at Ontario and asked: "How do we deal with it in Ontario? They are the exception. They don't have separate licensing for bars and taverns." They've put it at the point where now we have to make a decision about whether we are going to change the entire liquor licence board or whether we should make the move that we are that will eliminate an access point for young people to have cigarettes without having the interaction of a person to find out whether they're old enough to purchase the cigarettes. It's a conundrum.

1530

**Mr Sterling:** If the people of Ontario saw the way this government is acting in dealing with this—you know, if this group were put up against a group of vending machines, I think the vending machines would win. There's more logic to a vending machine. You put a quarter in and you get something out and it's fair with you as to the bargain. With this group, you put your quarter in and the government collects it before it hits the bottom of the pot, and confiscates it.

**Mr Jim Wilson:** You get nothing for your taxes but a bunch of nonsense.

**The Vice-Chair:** Any other speaker? If not, you've heard Mr Wilson's motion to amend subsection 7(2.1). All in favour of the amendment? Opposed? The motion is lost.

The next is a PC motion to amend subsection 7(2.2).

**Mr Sterling:** I move that section 7 of the bill be amended by adding the following subsection:

"Compensation

"(2.2) If, as a result of the operation of subsection (1), a person must remove a machine for the selling or dispensing of tobacco from a place the person owns or occupies, the Ministry of Health shall pay to that person an amount equal to the fair market value of the machine

on the day before the day this section comes into force less any amount received by the person from the sale of the machine."

**The Vice-Chair:** I rule the motion out of order pursuant to standing order 56.

**Mr Sterling:** I respectfully request, Mr Chairman, that we have the unanimous consent of the committee, the government members of the committee, to consider this motion notwithstanding that.

**The Vice-Chair:** I would like to read standing order 56 so everyone is familiar with what it says. "Any bill, resolution, motion or address, the passage of which would impose a tax or specifically direct the allocation of public funds, shall not be passed by the House unless recommended by a message from the Lieutenant Governor, and shall be proposed only by a minister of the crown."

**Mr Sterling:** Surely Mr O'Connor represents the minister.

**Mr Jim Wilson:** We've been told that.

**Mr O'Connor:** Sorry, Mr Sterling. I'm not a minister of the crown.

**Mr Sterling:** So what are you doing here? You're representing the minister, are you not?

**Mr O'Connor:** I'm parliamentary assistant to the Minister of Health and part of my role is to be here to represent her, but it doesn't make me a minister of the crown. On occasion I've heard my colleague the Vice-Chair here called Speaker, but it doesn't make him the Speaker.

**The Vice-Chair:** Not yet.

The next motion is a Liberal amendment regarding subsection 7(3).

**Mr McGuinty:** I'll be very brief on this one, Mr Chair. We've canvassed all the arguments. I'll start by reading it.

I move that subsection 7(3) of the bill be struck out and the following substituted:

"Temporary exception

"(3) Subsection (1) does not apply until the day that is two years after the day this section comes into force."

We're trying to deal with the issue of vending machines once again, and extend the period before which the ban would take effect to two years from the date it comes into force. The government amendment is going to provide for the ban to come into effect at the end of this calendar year. We thought two years was appropriate, for all the arguments already made, specifically because it's just a more humane and, I feel, civilized way to allow these people to adjust to a government bringing the hammer down on them.

**Mrs O'Neill:** I'd like to speak in support of this. I do feel that each of those who came before us was a small business person and, may I remind the committee, often a woman.

The percentage of the market that the vending machines hold, as we understand it, is about 1%. We're talking about a very small number of people and a very limited access to cigarettes and tobacco products. I really

can't believe that we can't support this for those few people, most of whom have less than 10 employees but who have put a lot of their life savings towards their businesses. Often they are family businesses: mother and son, we saw; brother and brother, father and son. They are not big conglomerates. I really feel they deserve every particular consideration we can give them, especially when we know their machines are obsolete. They've told us this. They're going to add to the landfill problem.

They are also people who have very few alternatives. In fact, one woman came and said she was approaching becoming a senior citizen. Others came who were definitely middle-aged. These people have not got alternatives to employment. What are they going to do now? They'll have debts to pay, no compensation, and only a few months to make a major adjustment in their lives, major financial changes in their assets and liabilities.

**Mr Jim Wilson:** I'm supportive of this motion because it's very similar to the motion Ms O'Neill just voted against by the Conservatives which talked about a three-year time frame.

**Mrs O'Neill:** "Similar" is the important word.

**Mr Jim Wilson:** I think the Liberal Party should be a little more consistent. They just voted against the PC motion. We're going to support the Liberal motion, but honest to goodness.

**Mr O'Connor:** We heard from the Liberals in bringing forward this motion that they feel there needs to be some compassion in dealing with this issue of the vending machines. I find it rather astounding that when the federal Liberal government decided to enact the federal legislation, it didn't include a little compassion in there. What we're trying to do at this point is recognize the need for some compassion, give them a date to go towards. Instead of the immediate hammer falling down like the Liberals did in Ottawa, we're giving them right till the end of the year to deal with this, which is an extended time from the three months originally proposed in the legislation.

**The Vice-Chair:** All in favour of Mr McGuinty's motion to amend subsection 7(3)? Opposed? Motion lost.

The next is the government's motion to amend subsection 7(3).

**Mr O'Connor:** I move that subsection 7(3) of the bill be struck out and the following substituted:

"Temporary exception

"(3) Subsection (1) does not apply until December 31, 1994."

For the obvious reasons that I've pointed out, unlike other governments that have decided to put these people out of business, we're trying to use some compassion and give them an extended period.

**Mr Jim Wilson:** That's just complete baloney. Other governments didn't put these people out of business; they negotiated with vending machine operators and came to a consensus which is reflected in the new law of Canada. The people of Ontario and the vending machine operators of Ontario are being denied those protections under that law because Bob Rae's government and his hordes feel they know best.

I want to ask the parliamentary assistant what guarantee he can give us that this time frame, as spelled out by the December 31 deadline for the banning of vending machines in this province, will actually be a longer time frame than the three-month phase-out period in the act. For example, Mr Parliamentary Assistant, you tell us you're not a minister of the crown. You can't give us assurances on much else and I'm sure you can't give us a date for when this bill will actually come into effect, so in fact your three months as spelled out in the original bill may turn out to be the longer time frame. You don't know. Tell me if you know something I don't know, but you can't guarantee this thing will come into effect in the near future. You have no control over what the Legislature will do.

1540

**Mr O'Connor:** I appreciate that argument. On many different parts of this legislation, we've had some disagreement, but I think the one area we have agreed on is the need to bring this legislation forward as quickly as possible to deal with the issue of trying to keep our young people from this terrible addiction. I don't see why there would be filibustering that wouldn't allow the government to move forward with this legislation.

**Mr Jim Wilson:** I'm not suggesting filibustering at all.

**Mr O'Connor:** It's not the intention of the government to delay this for any great deal of time. It's something we plan to deal with in this session. In this session, we know the calendar year ends at the end of June. We committee members can see right now that three months beyond that isn't December 31. We're giving an extended period of time even if, in the worst-case scenario, it was the last piece of legislation we dealt with. We were fortunate that it was the last piece of legislation in the last session and that we did have the support from all the committee members, all the government members and the opposition members, to allow this to get on the table so we could have this discussion. Given that generosity by the opposition members at that point, that we could deal with this and get it out to committee hearings, I would think this is going to move forward in this session.

**Mr Jim Wilson:** The government has a very strange view of how Parliament works. We don't give you pieces of legislation to come to committee because of some sense of generosity, Mr O'Connor. That's not part of our parliamentary system. We do it because we agree with the principles of the bill on second reading, and if your government happens to call it before a committee, fine. We have no control over your agenda. To constantly come back and say the opposition holds it up—you spun it on this bill for a while. You were the ones who dragged your feet over coming forward with any type of legislation. For months we never saw anything, yet we were being accused of holding something up, for goodness' sake. Let's not fool the public who are listening that there are behind-the-scenes generosity deals made on these things. We either believe in the principles of a bill and we support it, or we don't. And you're in charge of the agenda, unfortunately.

**Mr Sterling:** It's unfortunate that the parliamentary



assistant has abrogated his duties in representing the minister here this afternoon. It puts the opposition in a very difficult position, and it's obvious from his intransigence in dealing with a number of issues we had put forward. We had hoped during the second reading debate that we would be able to look at this bill constructively and that the government would not react in a negative sense to any suggestions the opposition put forward. We've seen nothing but negative reaction to what we have considered reasonable suggestions.

I can only assume from the parliamentary assistant's comments vis-à-vis compensation for vending machine owners that he's pushing us to the point where we have no choice but to go to committee of the whole House and deal with the minister. We're going through all this for naught, and we might just as well rise and report the bill at this time. If the parliamentary assistant doesn't feel he can handle this issue, as he seems to be indicating, maybe we should have the minister here so we can deal with it with somebody who can make some changes to the bill.

**Mr O'Connor:** I appreciate the honourable member's comments about whether we have the ability to move this forward. The key here is that the reason we've got consensus, the reason we had this go through second reading and got it out to committee hearings was because we agree that 13,000 needless deaths in the province every year from tobacco-related illnesses is intolerable and we have to deal with.

For him to now suggest: "Let's hold it up. We can't deal with it now because we don't like the amendments you come up with"—well, we had people come forward and ask us for a time extension. We're giving them an extension. We had people come forward with many constructive reasons why some areas need to be changed, and some of those changes are happening. For the member to suggest that we should drag this out, go into committee of the whole and not even deal with it at this point, I find reprehensible. I don't think that's a very good way of dealing with it.

This is a very serious health issue. We've got 40,000 Canadians who die every year from tobacco-related illnesses. We had a federal government that didn't want to deal with it. Mr Chrétien dealt with it in the way he thought was fitting, which I don't believe was a good approach, and now we see the member here suggesting that we delay this a bit further, going to committee of the whole House.

"We don't support it"? Well, we've heard his arguments that he doesn't support this bill many times over: "It's not good enough. It's not good enough." Well, we didn't see anything being introduced by the Tories. For all the 42 years they were in government, we didn't see it happen.

Now we've got a piece of legislation before us. I think it's a good piece of legislation. We recognize some impact it's going to have on some people, and we modified some areas taking that into consideration. Now for him to suggest, "We're not getting everything we want and we're going to drag this out and drag this out," and "Let's let a few more people die," I find that totally reprehensible.

**Mr Sterling:** I think the parliamentary assistant is ridiculous and inviting confrontation. If he wants us to hold up the bill in the Legislature, he can continue to act this way. I have a long record in dealing with these kinds of bills and trying to reach some kind of consensus. I've worked with previous governments, previous ministers and that kind of thing. But one thing I have required, one thing I have argued very strongly for, is fairness on all sides of this issue.

This government is not willing under this section to deal in fairness with people who have put up their life savings. They are confiscating these people's livelihood without compensation, and we consider that a very serious matter. I voted for this on second reading because I believe there are some good parts to this bill, but we really do require that people be treated with some kind of fairness in this province. You can't take away people's livelihood, you can't take away their assets without being fair and saying, "We'll deal with you in some fair manner." This is a terrible thing this government is doing to these small business people. This is awful. This is terrible, and we've got to fight for them. If they're not willing to see this and deal with it—

**Mr Jim Wilson:** They did that in Germany. We had a war over this issue once.

**Mrs Haslam:** We're doing what you asked us to do.

**Mr Jim Wilson:** We had a war over this type of issue, and it is not an exaggeration. Government coming in and confiscating property and wiping out the rights of its citizens did spark in part an uprising in this world. The principle is the same, on a smaller scale, because we're only dealing with a few vending machine operators. This government won't budge on an issue of fundamental fairness, because it's driving people out of business—

*Interjection.*

**Mr Sterling:** We believe in people's rights. You people believe in anarchy. We don't believe in anarchy.

**Mr Jim Wilson:** They're driving people out of business.

**Mr Sterling:** We don't believe in running over people's rights.

*Interjections.*

**The Vice-Chair:** One speaker at a time, please. I would ask all members to allow Mr Wilson to complete his remarks—he has the floor—and then you will have the opportunity to speak, if you wish.

1550

**Mr Jim Wilson:** Clearly, we've expressed our views quite strongly on this issue. We simply believe in fairness, that if you're going to take away the livelihood of families in this province, the government has a moral obligation and in fact should have a legal obligation—we're going to have to get some laws into this province that ensure governments can't act in this dictatorial fashion. When we see it happening in other parts of the world, we tell our families and friends that it's disgusting, comment in our living rooms that it's disgusting that another country, a communist country or something, would do that. And here, albeit on a smaller scale than

what we've seen in other parts of the world, is the exact same thing happening.

**Mrs Haslam:** It is not.

**Mr Jim Wilson:** It is exactly the same.

**Mrs Haslam:** What an exaggeration.

**Mr Jim Wilson:** It is not an exaggeration. It is exactly the same thing happening. You are confiscating property and business rights with no compensation.

**Mrs Haslam:** We are not confiscating property at all.

**Mr Jim Wilson:** Then what exactly are you doing, Mrs Haslam? What exactly are you doing when you put vending machine operators out of business? You are confiscating—

**Mrs Haslam:** We're not confiscating.

**Mr Jim Wilson:** I will read the act to you. You are confiscating their property—

**Mrs Haslam:** We're asking them to remove the machines.

**Mr Jim Wilson:** —and putting them out of business.

**Mrs Haslam:** Half the people who came here said that they had a percentage of their machines in tobacco, not all of them.

**Mr Jim Wilson:** By putting them out of business you're making their machines null and void.

**Mrs Haslam:** Not all the people who came here have all their products in tobacco machines.

**Mr Jim Wilson:** As somebody said, they're going to end up in the landfill because they're useless. You're making their machines and their livelihood useless. You're a bunch of communists, that's what you are, an absolute bunch of communists.

**Mrs Haslam:** And you're a fascist. So there. You want to get into name-calling? What a good use of our time in this Legislature.

**The Vice-Chair:** I don't think we want to—

**Mrs Caplan:** Mr Chairman, I suggest that one of the reasons people are so cynical about what happens at committees such as this is when we see this kind of behaviour coming from not only the government side but also from the Progressive Conservatives. People are watching these hearings. I think the least we can do is respect each other if we expect people to respect us.

**The Vice-Chair:** Thank you for the advice.

**Mrs Haslam:** It has to be on both sides, Elinor.

**The Vice-Chair:** Please. Mr Wilson, will you conclude?

**Mr Jim Wilson:** I will conclude my remarks by saying that is very nice, but I hope you never take this right away: the right of parliamentarians to stick up for their constituents as forcefully as they feel necessary to drive home a point to a government that clearly isn't listening.

**Mr Sterling:** I make no apology for the method or the amount or the height of any fight I undertake on behalf of my constituents. I don't want to be a wishy-washy Liberal like Elinor Caplan.

**Mrs Haslam:** That was uncalled for.

**Mr Jim Wilson:** It's absolutely called for.

**The Vice-Chair:** Mr Sterling, please. We're dealing with the problems at hand.

**Mr Abel:** She has contributed a lot, and I think that's very unfair.

**The Vice-Chair:** Mr Abel, did you wish to speak at this time?

**Mr Abel:** I just said my piece. Mrs Caplan came up with some excellent suggestions today, and Mr Sterling's comments are certainly uncalled for.

**Mr O'Connor:** I'd just close up this discussion, and it's too bad it's gone on to the degree it has. The fact is that the federal legislation which banned it right across the country, with the exception of some licensed premises, faced a problem here in Ontario. In their legislation they never dealt with the reality of these business people. What we did in our initial legislation was put in the three-month period, but after hearing from people, we recognized it was too short a time frame and extended it to December 31. I would just close with that.

**The Vice-Chair:** You've heard Mr O'Connor's motion to amend subsection 7(3). All in favour of the amendment? Carried.

All in favour of section 7, as amended? Opposed? Carried.

All in favour of section 8 of the bill? Opposed? Carried.

Section 9: The first is a Liberal motion to amend section 9, paragraph 2.

**Mrs O'Neill:** It's time for Mr McGuinty to present his motion, correct?

**The Vice-Chair:** Mr McGuinty, are you prepared to move?

**Mr McGuinty:** Yes. I'm still with the tour here, Mr Chair.

I move that paragraph 2 of section 9 of the bill be struck out and the following substituted:

"2. A school or a private vocational school."

What I am trying to do is to remove from the ambit of Bill 119 colleges and universities. First of all, let's understand that when it comes to smoking policy in our campuses there's hardly a state of anarchy. As Colleges and Universities critic, I have learned that there is no smoking taking place in classrooms. Secondly, I have learned that campuses are subject to municipal bylaws. Thirdly, I've learned that most colleges and universities have struck smoking committees of some kind in which students, administration and faculty participate, and they have established smoking policies on their campuses.

Remember again, whenever we stray away from the original intent of the bill, which is to make it harder for young people to start smoking, we get into trouble. Now we want to regulate what goes on at colleges and universities. I believe the average age for college students now is in excess of 25 or 26, and as you might imagine, there are many people going back to school at a post-secondary level in order to upgrade their education, their skills, their qualifications, to make them more marketable in the employment sector.



I spoke with someone regarding this issue and I know that the government motion—I guess I'll bring up those arguments at that time, but I'll make passing reference to them now—intends to provide, when it comes to colleges and universities, for a general rule that there's no smoking anywhere, but they've got a couple of exceptions.

The first exception: You can smoke outside. Fair enough. I think it's patently reasonable.

Secondly, you can also smoke in any of those areas which the government is going to prescribe some criteria for. We're not really sure what those criteria are going to be, but I suspect they will have something to do with separate ventilation systems. Am I correct in that regard?

**Mr O'Connor:** At this point there isn't anything that's going to suggest that we move forward with something as far as these separately ventilated areas. I think the key here that the government wants to point out—and I can see where he's got some confusion about maybe the intent of this, but the fact is we believe that people have the right to pursue education in a smoke-free environment. What we're talking about then are the portions of buildings where people go to colleges or university in the pursuit of their education.

If there is, for example, a pub facility on a campus, you're right, that would be regulated then by the municipality in the municipal bylaws. For those campuses that don't have a committee struck already, as you suggested, I would encourage perhaps that they do that and come up with their own smoking policies. The key here is that we wanted to make sure that people have the right to pursue their education in a smoke-free environment.

1600

**Mr McGuinty:** Again just to reiterate, there's no smoking going on in the classrooms.

I spoke with the fellow who made a presentation on behalf of York University, and he was telling me that there are 30 restaurants and pubs on the campus and 24 of those do not have separate ventilation. I just want to plant the seed here for the government members. That's 24 that do not have separate ventilation, so if you were to make separate ventilation a requirement, for instance, then what you're going to do is to unilaterally impose some very heavy costs associated with making the necessary changes to have them separately ventilated.

What you're also doing is, perhaps unwittingly here, you're going to discriminate against the restaurants and pubs found on our campuses and you're going to drive the patrons of those restaurants and pubs, particularly the pubs, off the campus, across the street and into a restaurant or a bar or a tavern which is run by somebody else who is not subject to the same kinds of regulations. I just want to make it clear that that's a very pressing concern that they have, that they're going to be discriminated against by virtue of having their pub or restaurant located on a campus. How do you respond to that?

**Mr O'Connor:** To address that, and I think the point you make is valid, that these facilities on campuses are very similar to other restaurants and establishments out beyond the campus, I think the concern that was pointed out to us was that they be on a level playing field, that

they not be subject to something above and beyond what would be expected elsewhere. I think that's a reasonable assumption to be made.

I can't see any reason why there would be regulations drafted that would be tougher for an eating establishment that has a smoking area on a college campus that is separate. You know, the purpose isn't for education at that point. They're an eating establishment, a restaurant or a pub, same as any other within the broader community. You're right that there needs to be a level playing field there.

**Mr McGuinty:** There are very few young people who are at colleges and universities, so we're not concerned here about young people picking up the habit at colleges and universities. I gather we're concerned with secondhand smoke, right? I gather that's the government's concern in this regard.

Again, the people who run these institutions are all big boys and big girls. They're subject to municipal bylaws. They already have designated areas where they can smoke. They have their residences on campus. Some of them smoke in their residences, in their own private rooms.

If you don't think there are any debates that have raged over the past 10 years on our college and university campuses regarding smoking you haven't been paying attention. In fact, in many cases they think we're way behind the times in terms of addressing it here in government.

My preference would be that we let colleges and universities address this on their own. They have been doing so effectively. I don't recall any presentations made here by anybody complaining about secondhand smoke in colleges and universities. If I'm mistaken then I stand to be corrected by any committee member. I don't recall any presenter here saying that kids were getting access to cigarettes on college and university campuses. Again, I'm quite prepared to stand to be corrected if anybody can recall anything that I did not hear.

I don't recall anybody asking that this provision be put in there because kids were getting access to cigarettes or people were having to put up with secondhand smoke. Our post-secondary institutions in this province are very advanced in their thinking relating to secondhand smoke. Many provisions have been put in place now to ensure that people aren't exposed to it. Many more will continue to be so in the future. I expect that at some point we're going to have a smoke-free campus, but when they do that, and we'll all be proud of it, they'll do it on their own, not because we told them to do it.

**Mr O'Connor:** Just to point out for some of the committee members who never had the opportunity as we went through a previous consultation within the ministry, it was brought up as an issue for adult educational institutions that they have the opportunity to pursue their education in a smoke-free environment. I can see why there is some concern over the way it was drafted in legislation, and there will be an amendment that hopefully clarifies some of that. But the key here is that people have the right to pursue their education in a smoke-free environment.

**Mrs O'Neill:** I don't know where to start, because Mr O'Connor has said so many things. First of all, he has said that we are talking about a smoke-free environment at the universities. We have a difficulty right now with the Minister of Education and Training of this province trying to interpret Bill 4 regarding suspensions. He's interpreting 20 days one way and school boards are interpreting it another way. I foresaw some of that difficulty when we were passing that bill.

Here we get the parliamentary assistant talking to us about, "Oh yes, we must be able to pursue our education in a smoke-free environment." I was on a university campus for two days last week, not in this country, true—a smoke-free environment in the classrooms, actually in the library. I've been in many university libraries; I've never seen anybody smoking in a library. I was in, however, on that same campus, a pub that's been there since 1886 which had designated smoking areas in it. I don't know whether it had designated smoking areas in 1886, but it did last Thursday.

All I'm telling you is that your definition, as you're explaining it, has not yet been very defined. It hasn't been very specific. I don't know how anybody in a post-secondary institution would know what you are speaking about.

We have residences. We saw many residences. Most of these residences do have a smoking area. It's a person's home. But a post-secondary institution—that's the way it's written here—likely means the campus, which is acres and acres, sometimes blocks and blocks, if you're talking about the University of Toronto.

The retail store: Is that going to be the same interpretation with pharmacy as institution is with campus? This is very complex stuff and it does change people's lives and their habits.

I don't feel that I would want my young people having to go over to Yonge Street instead of being able to use the campus on the U of T, if they so wanted to stay on the U of T campus and have a smoke. None of my kids happens to smoke, but I can put myself in those parents' places.

We had, and I'm going to bring back again, the group of students who came here from Etobicoke and were all smokers. They were all going to a drop-in centre. The counsellor who was with them said they found the best way to deal with the situation in that drop-in centre was to have the young smokers involved in planning, first of all, how they were going to get off smoking and, secondly, how they were going to handle it until they reached that ideal.

All of this just contradicts that. We heard that the average age of the university student is 27. I certainly think if one of us walked around the campus around here even, we'd find that out. They're much older students.

The other thing that I have a great deal of respect for and that hasn't been mentioned is that most of these campuses—and indeed I think we did have one student council from a secondary school, but I'm talking about student government. I happened to have been involved in university student government. It's a very, what should I

say, well regulated, responsible, accountable body. They are very accountable. Let me tell you, I've been there.

I just feel that this can be handled well. We've heard the witnessing that it is being handled well. I've had three children go through three different universities, and they certainly felt that their problems were solved in a manner in which their peers were consulted. I just don't think that we can put a school, which we know is likely at the most five acres, and a post-secondary educational institution, which is block upon block, maybe hundreds and hundreds of acres, into the same category; and then a private vocational school, which is usually a very confined building. They just don't sit together.

**1610**

You made the statement, "Maybe there will be an amendment." If there's going to be an amendment, let's hear it, folks. We're here at this crucial point of this bill. We're talking about however many universities—what are there, 22 in the province?—a large number of universities with very extensive campuses. We're going to change people's lives and, as my colleague has just said, maybe cost universities a lot of money. If you're going to put regulations that are going to state certain things, let's tell them up front we're going to do that, but then we have to give them some grants. They are suffering.

We really have to know what this means. It's really unfair. That's why I voted against the section of the bill that talked about a retail establishment, because I thought your definition was wet, and I think your definition is wet here again.

**Mr Jim Wilson:** We won't be supporting this Liberal amendment. I think if members refer to the government amendment that's coming up, it deals with this issue and allows some exceptions through regulation for what I assume will be the pub areas on a campus. We've already heard during the committee hearings that this bill won't affect smoking in the private residence rooms of individuals, which was a concern of the student council representations received from those student councils. So I think the government amendment coming forward covers the concerns that have just been expressed by my colleague in the Liberal Party.

**Mrs Haslam:** I just wanted to make mention that although the average age of students may be 27, it still does get students at a younger age. I'm in an exact opposite position, where I have a son who started smoking at 19 when he came into Ryerson here at school. So it may be the average age is 27, but we still find people coming into post-secondary education who haven't started to smoke yet and are at an age where they could start in these facilities. So I have a concern about that.

I was hoping that we could discuss some of the parameters around exactly what the "post-secondary institution" means, and I'm glad to hear that we're talking about the educational facilities, because I do hear a concern around the pubs and around some of the other areas on a campus. I think we should be very clear that that's not what we're talking about.

**Mrs Caplan:** I'm interested in the government's amendment. What I'm looking at are the exceptions.



What I want to know for the record from the parliamentary assistant is whether or not the exceptions—first is exemption (2), “outdoor areas in certain places.” I think that’s self-explanatory.

Exception (3), “private areas in certain places”: What this says is, “The prohibition set out in subsection (1) does not apply to the parts of places referred to in” all of those institutions, primarily, which are not open to the public. I’d like you to give me some examples of what that would be.

The exception in subsection (4): “The prohibition set out...does not apply to an area set aside for smoking within a place referred to...if the area is identified as an area where smoking is permitted.” The question that I have is, will these have to be provincially designated or will you be able, by regulation, to permit the governances of the institutions listed under 1 through 13 to determine which places are exempt?

Just to finish my question, because it really is all in one, I want to know whether or not this will satisfy the concerns that have been raised by my colleagues Mr McGuinty and Mrs O’Neill regarding pubs on universities, designated areas in university residences, for example, and how you’re going to identify those. Will it be by regulation and will there be a process that will be open to discussion around how those will be decided?

**Mr O’Connor:** In most instances where we’re going to have to deal with some areas in regulation, it would be through a consultative process. There’s no doubt about it. To help answer the question, I would ask Frank Williams to help with the legal things, because here we get into a point where it might be easier to get a legal opinion that might just clarify the concerns that you and your colleagues raise.

**Mr Williams:** I’m not sure just what parts of it you consider legal and what parts of it are really how we’re going to implement the policy. Certainly the part of your question that referred to subsection (3), those areas that are not open to the public, for example, we don’t want to necessarily restrict an owner of a private business from being able to go into the back room and have a cigarette if he or she wants. That’s not our intention. It’s areas that are accessible to the public.

Likewise, some retail premises are operated in private homes. Part of it’s a business and part of it’s the home. So in the part that would be the business, there would be restrictions on smoking; in the part that’s the private home, there would be no restriction. So that’s part of where the subsection is aiming at.

**Mrs Caplan:** That’s because you’ve included places like hairdressing establishments and barber shops?

**Mr Williams:** That’s correct.

**Mrs Caplan:** It’s quite broad, “a place that belongs to a prescribed class.” That’s kind of legalistic. But the intention here is that it would be only in those places where the public come in, and wherever it is private, they would be automatically exempt by this legislation.

**Mr Williams:** That’s correct.

**Mrs Caplan:** That’s exemption (3), certain private areas?

**Mr Williams:** That’s right. Subsection (4) is an attempt to address the types of issues that Mr McGuinty has raised.

**Mrs Caplan:** I’m clear on exemption (2), outside. I think that doesn’t require any process. I have no problem with exemption (3). I don’t think you’re going to need a process on that. That’s pretty clear.

On exemption (4), how are you going to determine who is exempt? I don’t want to see a big bureaucracy established to have to do this. I think the point that Mrs O’Neill and Mr McGuinty made is a very good point; that is, that many of the universities have committees and so forth. Does this legislation allow those committees to grant exemptions?

**Mr Williams:** In essence, no. This is a policy question. I can’t answer whether the government in fact is going to do this, but there’s nothing to prevent the government from consulting with these various committees, seeing what their criteria are and perhaps adopting them as the criteria that would be prescribed in the regulation. That would be a partial answer.

**Mrs Caplan:** Is there anything in this legislation which would permit delegation to an authority for the purpose of these exemptions?

**Mr Williams:** The legislation the way it’s written does not provide subdelegation, but as I say, the regulation could adopt the criteria that a committee established.

**Mrs Caplan:** I would be much more comfortable if you would consider an amendment to your amendment that would permit delegation, where you have autonomous bodies that have set up the criteria, to allow them to enforce this regulation rather than having this central control of government trying to make these exemptions for all and sundry on this list, particularly post-secondary institutions. I think you could probably get an amendment to this quite easily or I’d be quite prepared to propose an amendment that would give, through the regulatory power, the right to designate for purposes of exemption (4). I just think that makes a lot of sense, if you would be willing to entertain that.

**Mr O’Connor:** I appreciate the intent you’ve put forward here, Ms Caplan, but I think in an effort to try to be as straightforward as we can with this, that might make it just a wee bit more ambiguous. I do believe we need to reach into the community as much as we can as we develop these regulations for the ease of implementation.

**Mrs Caplan:** Perhaps you don’t understand. All I’m suggesting is that you give yourself the power to delegate your authority. That doesn’t take anything away. It’s a very simple amendment to your legislation that would allow government the right to delegate for the purpose of these exemptions. I think, if anything, it would make it clearer and easier and less bureaucratic.

1620

**Mr O’Connor:** In the opportunity here that I’ve had to consult with Brenda Mitchell, who has been helping us through this process within the ministry, she suggested that we may be able to deal with this in section 10.1 in our amendment coming up. But maybe to help clarify

some of the other elements of your concerns, I'd ask Brenda if she would like to address some of them.

**Ms Mitchell:** I think one of the things that's changed in the act and why I suggested that this may be raised by you under our motion for section 10.1 is that when we prepared the amendment to section 9, section 9 now deals basically with non-smoking areas, and the regulatory authority for designating smoking areas has been moved to section 10.1 under our motions. I think the question you raised relates to designating smoking areas.

**Mrs Caplan:** I'm looking at 10.1 and I don't see there where you have the authority to delegate either.

**Ms Mitchell:** No, I'm just saying in terms of the section of the act where it would be dealt with, it's now section 10, because previously in the bill as printed, the authority to designate it a smoking area was under section 9, paragraph 1. When the amendment was written for section 9, that regulatory authority for exempting a smoking area was taken out of section 9 and moved into section 10. That's the point I'm making. I think Frank wants to clarify.

**Mr Williams:** I agree with Brenda, but I think perhaps if I could discuss with legislative counsel, if we could maybe stand your comments down till later, you might want to consider that. If I can talk to legislative counsel, I'm thinking that perhaps we can deal with it even in the regulation-making section, which is 18, which ties again into section 10.1.

**Mrs Caplan:** Could I request that we set this down so that you can consider that?

**Mr Williams:** I'm just talking about this part of the discussion, because it relates really to Mr McGuinty's motion. We're not talking about the government motion yet.

**Mr O'Connor:** I think what we're dealing with would come under section 18 then, regulation.

**Mrs Caplan:** The advice from counsel is that we set this section down and move on to the other sections while you—

**Mr Williams:** No, I was talking not the section, but just this part of the discussion until I get a chance to maybe discuss with legislative counsel the best way of doing it.

**Mrs Caplan:** Then we should be discussing another motion instead and not vote on this.

**Mrs Haslam:** We're not on that yet, are we? We're still on the Liberal one.

**Mr O'Connor:** We're actually on Dalton's.

**The Vice-Chair:** Thank you for the suggestion to stand it down. Mr McGuinty.

**Mr McGuinty:** Just so we're clear about what my motion does, again it removes colleges and universities from the ambit of Bill 119. We have to look at the alternative, obviously, so members can decide which is better. The government amendment provides—and correct me if I'm wrong—that there's no smoking on college and university campuses anywhere except you can smoke outside and you can smoke in those other places which meet certain criteria which have yet to be drawn up and

enunciated by the government. Am I correct, Mr Parliamentary Assistant?

**Mr O'Connor:** In part of your analysis, yes, you could be correct. The key here is that what we're trying to deal with, and I guess maybe we're not getting the point out clear enough, is the places where the education takes place and parts that a person needs to go to in the pursuit of their education, which, for example, Ms O'Neill presented as libraries.

**Mr McGuinty:** Maybe I'll ask it this way. Will residences be excepted? Will students be allowed to smoke in their residences?

**Mr O'Connor:** At this point it's not in the legislation that would restrict them from the ability to smoke in a residence.

**Mr McGuinty:** The regulations won't ban smoking in residences?

**Mr O'Connor:** It's not the intention of the regulation to ban smoking in residences.

**Mr McGuinty:** Okay. Pubs and restaurants found on campuses: Will the regulations ban smoking in those? Will they have to comply with any regulations that their counterparts in another part of the city don't have to comply with?

**Mr O'Connor:** The intent in dealing with the pubs and restaurants would be that they would be subject to the same regulations and criteria that would be expected in the rest of the community, not on the campus. If a municipality has, and some municipalities have, some pretty stringent smoking bylaws, the more restrictive would be in place. Whether it be downtown Toronto, the University of Toronto, or whether it be a campus outside of the city of Toronto, they could actually be complying with different rules, but they would be related to the municipality in which they happened to fall.

**Mr McGuinty:** All right. Then I want to indicate that the parliamentary assistant has gone a long way towards alleviating the concerns that I've raised and that were raised by students and representatives. I still want to go ahead with my motion on the basis of principle, because I just think that colleges and universities are quite capable of managing their own affairs, including the issue of smoking on campus.

**Mrs O'Neill:** I have to ask the same question my colleague just did. The "prescribed criteria," and I know this is in the motion that Brenda referred to: What does that mean? Is that going to be criteria that are going to be established in regulations and it's only going to refer to this section of the act? Is that what we're talking about, "prescribed criteria"? Could you give me some example of what we're talking about? Are we talking about workplace rules, square footage; what are we talking about?

**Mr O'Connor:** I'm grasping for a good definition here that would give you an area that we're talking about as prescribed. In an effort to help me along, I'd ask Brenda Mitchell to assist me. The key here is that we're trying to not make it exclusive so they're going to be more restrictive on campuses but be able to fit in with the rest of the community which that campus falls within.



**Mrs O'Neill:** This is why I have so much difficulty, because every time we ask you what it means, we can't find out. This can't be a great big secret. This issue is of very high public interest, talking about hundreds of thousands of students. They want to know what's going to happen.

**Mr O'Connor:** I appreciate the concerns that you've raised, and in fact as I stated before, we went through a consultation a year ago at which time it was presented that adult education institutions should be part of the legislation. It was put into the legislation, and as we went through this consultation process, it was pointed out to us, quite ably, by people from these campuses that there was a problem. I think what needs to take place now is some further consultation with those people while we draft some of those regulations.

I'd like to assure you that it's not going to happen in isolation of the abilities that these campuses have of providing us with some information to deal with it in a fair and just fashion. We will consult with the colleges and the universities, the students or the establishments that are concerned at this point.

**Mrs O'Neill:** I hope that will be picked up in Hansard.

I have one other question and I guess it goes along with Mrs Caplan's line of questioning. I can't understand why "in private places" in your amendments that you're going to present that you haven't included section 5, which are the post-secondary institutions, as having places that are not open to the public. In my mind, that would cover such things as a smoking room for students in a residence or a residence room. All of a sudden there are no private areas on campuses of a university. Maybe you're trying to get away from workplace smoke where a professor might go into his office; I don't know.

You have to guess all the way through this bill what you're doing. That's very, very frustrating, and it's also, in my mind, confusing to the general public who are going to have to live with this. You've got it for all these other places. You've got it for a pharmacy, you've got it for premises of a financial institution, an establishment where goods or services are sold and you've got it for a self-serve laundry. A place of the self-serve laundry that's not open to the public would have to be part of the workplace then, unless it's part of the person's home.

**Mrs Caplan:** In a back room.

**Mrs O'Neill:** I know; a back room is a work environment then. You know what I'm saying? It's just full of contradictions.

1630

**Mr O'Connor:** I appreciate the concerns that you're raising, and I guess that's why at this point we find ourselves in a situation where, though when the draft legislation was circulated we heard from 240 different written presentations and 34 oral, this wasn't pointed out as a real problem at that point. That's why, when we take a look just across the road at the University of Toronto and we take a look at the size of that facility, I suggest that we do need to go and consult with people from the universities, that we go and talk to people and find out

where we should be putting them in for further definition through the regulations. I don't think it's something that should be done in isolation and I agree that we need to go further and go and talk to these people. It's not as simple as we'd like it to be—life's never like that—but we do need to realize the fact that these people have some legitimate concerns and we want to address those concerns, just as you are doing on their behalf in this committee.

**Mrs O'Neill:** I'm certainly going to be supporting this motion. I feel that universities have very big decisions to make, much bigger than this, and they are very capable and they are very responsible regarding the health of their students. I think that the students, the professors and the administrators of post-secondary institutions could easily make some very reasonable and likely rules that the government could live with within their own purview. They should not be part of Bill 119.

**Mr Sterling:** I appreciate what Mr McGuinty and Mrs O'Neill are talking about, but if you look at it from the other aspect, from the other point of view, I think that the government amendment is a good one. What it does is it says, "You're in but there will be specific designated smoking areas," in their pubs and wherever is necessary in the university. I think you have to trust the people to get together to make regulations which are somewhat reasonable. But to say universities are out because they are responsible people in terms of what they're doing is not protecting the non-smoker who has to take in the secondhand smoke. What is the protection for the non-smoker who goes into a university that doesn't act responsibly or a college that doesn't act responsibly under this particular section of this act?

We are saying here, then, that you have school boards—there are lots of school boards which have banned smoking a long, long time ago and have acted in a very, very responsible manner in terms of dealing with the smoking issue in their establishments. This is, in my view, much more important than where we sell tobacco. I think that's more a philosophical issue. This is an issue which really affects secondhand smoke and people who are exposed to secondhand smoke. Why should there be any less requirement on a university to establish rules to assure people that there are non-smoking areas as there would be in a self-serve laundry or in a school board or anywhere else?

What we're talking about here is not saying that a university is responsible or will reach reasonable conclusions. What we're doing is guaranteeing a floor for the non-smoker. We're not saying that smokers must have access to everywhere to smoke cigarettes. This is the issue. The issue is the other way around as far as I'm concerned. What we're trying to do here is set a bare minimum in some public places in this province where you must go in order to get a higher education and that you can be assured that the university or the college is going to have a policy which will assure you that you can avoid secondhand smoke in most cases, if you so choose. To take them out in a blanket way I think is not responsible.

I wanted to raise that issue because I think that while

there's a problem there, there is also a problem in not including it in Bill 119.

**The Vice-Chair:** Thank you. Any other speakers? If not, you've heard Mr McGuinty's motion to amend subsection 9(2). All in favour of the amendment? Opposed to the amendment? The amendment is lost.

The next is a government motion to amend section 9.

**Mr Sterling:** Do you have my amendment as well? I didn't know if you wanted—

**The Vice-Chair:** Section 9, paragraph 8.1, is it?

**Mr Sterling:** I didn't know whether you wanted to deal with that one or the other one. It doesn't matter to me.

**Mr O'Connor:** We could deal with mine first.

**The Vice-Chair:** That's the way it's been listed here, 1, 2, 3, and then the PC, because of the numbering. Is it in order to go on?

**Mr Sterling:** I don't know which makes more sense.

**The Vice-Chair:** Well, the next is paragraph 9.8.1.

**Mr Sterling:** Which way does the parliamentary assistant wish to do it? Do you want mine first or yours first?

**The Vice-Chair:** Mr O'Connor, which do you prefer? Can I use that term?

**Mr O'Connor:** Maybe in a fashion to allow this to proceed, if I was to read my motion and then perhaps Mr Sterling might want to speak to his motion in the light of the motion as presented. Either way, I'm quite flexible.

*Interjections.*

**The Vice-Chair:** Yes, I realize that, and we have copies of the government motion so it doesn't need to be read. Right. We don't want two on the floor.

**Mr Sterling:** Which way do you want us to go, Mr Chairman?

**The Vice-Chair:** Mr Sterling will proceed with his motion.

**Mr Sterling:** I move that section 9 of the bill be amended by adding the following paragraph:

“8.1 The common areas of a shopping mall that are used as a corridor to connect the retail establishments, restaurants and other leased premises in the mall and including any area that is close to establishments that serve food and drinks and is used by the patrons of these establishments as an eating area.”

I feel that enclosed shopping malls are a significant public area where people are subjected to secondhand smoke. I would suggest, in conjunction with the government amendment, that it be included in subsection (4) of the government amendment; that is, that the prohibition I'm setting out here in terms of shopping malls would not apply to areas which are identified where smoking would be permitted. In other words, I would include 8.1 but say that when we deal with the government amendment I would move to amend that to include it as part of subsection 4, where there could be permitted areas. What you would have as a result of those two actions would be that generally there would be a ban on smoking in enclosed shopping malls, but there might be areas in the

shopping mall where smoking would be permitted, but those would be clearly identified.

**Mr O'Connor:** I appreciate what you presented to us. I guess the one difficulty I have is the fact that unfortunately I haven't had the opportunity to have a broader discussion around this with my colleagues. I appreciate where you're coming from. I don't know whether we would not have the ability to move forward with this type of change through regulation down the road, but at this point maybe I could ask for some legal opinion whether we could move forward with this at a further point. At this point, I haven't had the opportunity to really have this discussion with my colleagues, though I appreciate where you're headed with this.

**Mr Williams:** Certainly there is no problem as the bill is presently drafted or as amended, if it's amended according to the government motion. In either case, the government could move ahead at a later date to add shopping malls or whatever other area that was to be prescribed by regulation.

1640

**Mr O'Connor:** My only concern, Mr Sterling, is the fact that as we went through this debate, there were a large number of areas that were laid out in section 9. We did hear some substantial debate through this process. This not being part of that debate on which places there was going to be the ban, we haven't had the opportunity to hear from some of the owners of these types of facilities. So we haven't had the opportunity to talk to that part of the business community.

I can see where your intent is. I think it's very good and I think perhaps it's something that maybe needs further consultation so that if we were to move forward this year it should happen in a regulatory fashion, knowing we have that as an ability. I think you've certainly raised a point here. I think we do have some difficulty with it, though not the intent.

**Mr Sterling:** If you need some time to talk to your colleagues and you can deal with this tomorrow morning, fine and dandy, we'll stand it down. If you're talking about a longer period of time, then I guess I would want to push the issue. What are you talking about in terms of consultation?

**Mr O'Connor:** I think there needs to be a broader discussion on this issue as you've presented it here.

**Mr Sterling:** Why?

**Mr O'Connor:** I think as we circulated the bill and had our public hearings, this part of the business community didn't realize they could be impacted with an amendment of this fashion. I do think that in this element of fairness you talked about, that discussion does not need to take place. I appreciate the intent you've put forward here, but I think there still needs to be some broader discussion on that.

You'll note too that in our legislation we have the ability for some jurisdictions that want to proceed far beyond what we have for provincial rules. They have that ability to do so as well through a municipal bylaw, for example.

**Mr Sterling:** You know, consultation: There is a valid



argument that you should consult with people in terms of regulation and that kind of thing. But I would hasten to say that most mall owners would welcome this kind of legislation so that it would be clear to their patrons that what they were doing in fact in terms of restricting smoking to certain areas was a government edict. That's what they would prefer to act on, and therefore they're all acting the same way and therefore there's none of this cross-commercial argument that takes place any more that you go to mall X and you can smoke anywhere and in mall Y you're restricted to certain areas. In fact, in most malls I'm aware of, smoking is restricted to certain areas at the present time.

**Mr O'Connor:** Just the eating part.

**Mr Sterling:** I guess what you have to gauge here, or what the government always has to gauge, is that if it is a serious problem, which I believe it to be, then if you're going to act this way anyway, well, the sooner the better in terms of what you're going to do.

I also mentioned to you as well that as I understand it, and maybe legislative counsel would correct me, if in fact you ran into something, again, you don't have to proclaim this section or this part of this section if it was a horrendous—you know, if everybody ran at you and said that there's this tremendous problem associated with shopping malls.

But I'm interested in strengthening this law, and we're legislators here. We have the right to make some decisions here. We talk to people in our constituency. I just don't see this in terms of there being a tremendous number of downsides on the consultation end of it.

**The Vice-Chair:** Ms Haslam.

**Mrs Haslam:** God, he talked so long, I almost forgot what I wanted to say.

On the side of consultation, I agree. I think that without it being in the discussion paper, without it being in the legislation to have them come forward and give some sort of idea, I would be nervous about putting this in place.

My question, though, is around 13, "a place that belongs to a prescribed class." Could what Mr Sterling is suggesting regarding common areas of a shopping mall be interpreted as a place that belongs to a prescribed class? Therefore, could we do that as part of the regulations or as part of 13?

**Mr Williams:** That's correct. The way section 9 was originally drafted, it talked about "a prescribed place," which got us into the rather awkward position of having to prescribe each place by name and that wasn't the intention. So we wanted to do it by general prescription. It could be shopping malls or it could be whatever other class of public place that we wanted to prescribe by regulation.

**Mrs Haslam:** In order for that to happen, that would be covered under regulations then? There would be a list in the legislation and then this particular one would go under regulations and would allow for some consultation before it was put into regulations?

**Mr Sterling:** Maybe.

*Interjection.*

**Mr Sterling:** Not with us.

**Mr Jim Wilson:** It doesn't come back to the legislators here, obviously.

**Mrs Haslam:** No, but I'm more worried about people in my riding who are in the situation where suddenly we have put something into legislation that they've had no input on, and that is my concern. I would rather err on the side that they have input and be able to look at it as part of the regulations. Anyway, you've answered my question. It can be handled under paragraph 13 as a designated class and it can be done under those auspices following consultation with malls.

**Mr Williams:** I guess the government always has the prerogative to move or not move ahead with a regulation, either with consultation or without consultation. So my answer would be basically, if you want to consult, you can take as much time to consult and then pass the regulation or pass the regulation to come into effect on some future date, but it would be up to the government to decide how it wants to proceed. But the authority, the way it's drafted now, is open-ended and you can interpret it the way you want.

**Mrs Haslam:** Mr Sterling has brought up a mall as being an area. In looking at 13 things, and we couldn't list everything, what other things didn't we list as an example that we looked at that we didn't list? I mean, the list goes on for ever and a day, I would assume.

**The Vice-Chair:** Is there a response to that?

**Mrs Haslam:** No, I don't need a response. Thank you.

**Mr McGuinty:** I think this is a very good amendment and I'm going to support it. We were talking earlier about colleges and universities and how people who are required to complete an education have to travel through those hallways and on the campus and different areas and there is a concern for protecting people who attend those institutions from secondhand smoke.

I think we move one heck of a lot more people through shopping malls than we do through our colleges and universities and they're going through there, by and large, I think the great majority of them, to purchase food, to buy sustenance, so they don't have an option, whereas in a way you could argue that it is optional as to whether you're going to attend a post-secondary institution.

I do have a question, though, for Mr Sterling. The first part of the motion describes a shopping mall and then you go on and it says, "and including any area that is close to establishments..." I guess my first concern is, what does "close" mean? It says, "and including any area that is close to establishments that serve food and drinks and is used by the patrons of these establishments as an eating area." What is it that you're saying by that?

**Mr Sterling:** My instructions to legal counsel were that I wanted to include all the common areas in a mall. In some of the common areas, as you know, for instance in the Rideau Mall in Ottawa, there's a large eating area where people buy from vendors from various parts, and I think in those areas any smoking should be done in one designated area so that other patrons who are eating at

that time are not bothered by that smoke. That's why I suggested that it be dealt with under subsection (4) of the government's amendment in terms of allowing specified areas.

**1650**

That's the way it was drafted after my instructions were given to legal counsel. I thought it would have been an amendment which just said "common areas in shopping malls," end of quote, finished. I didn't want to include restaurants in this. I didn't want to get into the debate on restaurants within a mall or inside a retail store. I didn't want to try to contemplate all of the other machinations that occur in a shopping mall.

I wanted to basically deal with the areas where people had no choice but to walk. If they were coming in the entrance and they were going to the library, or they're going to the store, or they were going to an eating establishment, they have to walk through a certain area and I just don't think they should be subjected to secondhand smoke. This was the result of legislative counsel in terms of that amendment. I'm quite willing to change it, as long as the intent is maintained, if better drafting can be found.

**Mrs Caplan:** I'm also very supportive of this amendment. Fairview Mall is in my riding and I know that North York does have a bylaw which is very progressive as far as the designation of no-smoking places, but smoking is permitted in the food court and there are big ashtrays and things in the main area and it can be quite unpleasant as you're walking through. I think this amendment that would designate shopping mall common areas perhaps is the way to define it. I'd leave it to legislative counsel to suggest changes in the wording.

While I'm aware of the section that allows for the designation of certain places in the government's amendment, just as the government amendment designates very specific places such as hairdressers and barber shops and that sort of thing, I really do think it is appropriate and I'm not concerned about designating common areas of shopping malls which are enclosed as areas where there would be an outright provincial ban as part of the anti-smoking legislation. I would urge the government to accept this amendment because I think it is worthwhile, it's thoughtful and I think it would be acceptable.

On the point Mr Sterling made, which is that you'll have time to have your discussions and consultations and so forth between now and proclamation and you can delay proclamation of that section should you wish, you can also refine it and define it by the regulatory powers that exist in the legislation.

I'm going to be supporting this amendment and I would encourage the government to accept it.

**Mr O'Connor:** I appreciate the comments. I would like to have some discussion with legal counsel to make sure that what we have for wording and everything is appropriate and how it would fit into our legislation. I don't know whether we need some time to deal with that or not, but—

**Mrs Caplan:** It's five to 5; maybe we could—

**The Vice-Chair:** Thank you. Mrs O'Neill.

**Mr Sterling:** Perhaps I could table this tomorrow morning we could vote on it right away.

**The Vice-Chair:** We have two people who have indicated they'd like to speak.

**Mr Sterling:** Oh, I'm sorry.

**The Vice-Chair:** Can we have them speak? Mrs O'Neill.

**Mrs O'Neill:** I would like to support this motion. The city I was in last week had smoke-free shopping malls as well. You would be very surprised what a difference that makes in the entire mall, just to the appearance of the mall: the cleanliness, let alone of the air, of the actual mall itself, the floor, the windows, because all of those things, as we know, are victims of secondhand smoke.

I do think it's possible. I think there needs to be some reworking of this particular suggested amendment because this business that Mr McGuinty questioned, "is close to establishments," I do think is going to envisage in my mind litigation as to what does that mean. We really don't know what it means.

I wanted to ask a question, and I guess it's of legal counsel. The exemption, then—13, 4—would permit a self-enclosed restaurant to have an exempt area. Would that be correct, even if we have the intent of Mr Sterling's amendment?

**Mr Williams:** I'm sorry. What section was that?

**Mrs O'Neill:** That's 13, 4 of your government amendments that we haven't dealt with yet, smoking in certain places. Would that be permissive, so to speak, in restaurants? And/or they have licensed bars in malls. Would an exemption be able to be permitted in an enclosed store, then? I think it would, but I just wanted to have it on the record. If we insert Mr Sterling's amendment and then of course have the government amendment presented and accepted, would the one permit the other to have the self-enclosed restaurant and/or bar?

**Mr Williams:** I'm sorry. I was having trouble finding the section that you were referring to. I assume you mean paragraph 9(1)13 and subsection 9(4). Is that correct?

**Mrs O'Neill:** Right.

**Mr Williams:** Okay, because I was having trouble finding what you were referring to.

**Mrs O'Neill:** Because it's not in the bill, of course.

**Mr Williams:** I'm sorry. Can you repeat the question? Now that I've found what it is, I can better answer it.

*Interjection.*

**Mrs O'Neill:** Could you please let me ask this question? I wanted to know if the amendment Mr Sterling is presenting would then, accompanied by this 13 and (4) of section 9, protect restaurants and/or bars and pubs in shopping malls that wanted to have a designated smoking area.

**Mr Williams:** I've got two problems. One, I don't have a copy of Mr Sterling's motion, so I'm a bit pressed to partly answer your question.

**Mrs O'Neill:** I'm not surprised.

**The Vice-Chair:** In view of that fact, can we stand this down until tomorrow?



**Mrs O'Neill:** Yes.

**The Vice-Chair:** Would your response be in order tomorrow morning? Is that acceptable? Agreed?

**Mrs O'Neill:** No problem.

**The Vice-Chair:** Ms Haslam?

**Mrs Haslam:** Actually, I like the amendment. I have some concerns about the ambiguousness of the serving food in areas, because I know that in Fairview Park Mall in Kitchener, there is smoking in the food court area and cafeteria area, and I want to be sure that's made very clear in the legislation.

Also, I understand Mr Sterling suggested delaying the proclamation of this should there be a large contingent of people coming forward with this being a problem. I accept that. I'm just concerned that in a political arena it's not used as a political football, having it come forward with a lot of complaints and then saying, "We

told you this wasn't going to work." That's my concern. So I'd like to be very clear that that is my concern in supporting this particular motion.

**The Vice-Chair:** It's agreed then that Mr Sterling's motion to amend section 9, paragraph 8.1, is stood down until tomorrow. Agreed?

**Mrs O'Neill:** I agreed, with the condition that it's going to be looked at and reworked. Is that correct?

**The Vice-Chair:** Yes, that was your request and that is undertaken by counsel.

**Mr Williams:** I'll endeavour to look into the member's question.

**Mrs O'Neill:** Fine, thank you.

**The Vice-Chair:** Anything further at this time? If not, this meeting is adjourned until 10 am tomorrow, same location. Thank you.

The committee adjourned at 1659.











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## STANDING COMMITTEE ON SOCIAL DEVELOPMENT

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\*O'Neill, Yvonne (Ottawa-Rideau L)

Owens, Stephen (Scarborough Centre ND)

\*Rizzo, Tony (Oakwood ND)

\*Wilson, Jim (Simcoe West/-Ouest PC)

*\*In attendance / présents*

### **Substitutions present / Membres remplaçants présents:**

Abel, Donald (Wentworth North/-Nord ND) for Mr Martin

Caplan, Elinor (Oriole L) for Mr Beer

Haslam, Karen (Perth ND) for Mr Hope

Frankford, Robert (Scarborough East/-Est ND) for Mr Owens

Sterling, Norman W. (Carleton PC) for Mrs Cunningham

### **Also taking part / Autres participants et participantes:**

Cunningham, Robert, legal counsel, National Campaign for Action on Tobacco

Ministry of Health:

Mitchell, Brenda, manager, tobacco strategy unit

O'Connor, Larry, parliamentary assistant to the minister

Williams, Frank, legal counsel

**Clerk / Greffier:** Arnott, Doug

**Staff / Personnel:** Filion, Sibylle, legislative counsel

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## Legislative Assembly of Ontario

Third Session, 35th Parliament

## Assemblée législative de l'Ontario

Troisième session, 35<sup>e</sup> législature

# Official Report of Debates (Hansard)

Wednesday 9 March 1994

# Journal des débats (Hansard)

Mercredi 9 mars 1994

**Standing committee on  
social development**

**Comité permanent des  
affaires sociales**

Tobacco Control Act, 1993

Loi de 1993 sur la réglementation  
de l'usage du tabac



Chair: Charles Beer  
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## LEGISLATIVE ASSEMBLY OF ONTARIO

## ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON  
SOCIAL DEVELOPMENTCOMITÉ PERMANENT DES  
AFFAIRES SOCIALES

Wednesday 9 March 1994

Mercredi 9 mars 1994

The committee met at 1012 in room 151.

TOBACCO CONTROL ACT, 1993

LOI DE 1993 SUR LA RÉGLEMENTATION  
DE L'USAGE DU TABAC

Consideration of Bill 119, An Act to prevent the Provision of Tobacco to Young Persons and to Regulate its Sale and Use by Others / Projet de loi 119, Loi visant à empêcher la fourniture de tabac aux jeunes et à en réglementer la vente et l'usage par les autres.

**The Vice-Chair (Mr Ron Eddy):** Good morning, ladies and gentlemen. Welcome to the social development committee and clause-by-clause consideration of Bill 119.

We were dealing with a PC amendment to subsection 9(8.1) of the bill. Mr Sterling had moved that that amendment be stood down.

**Mr Norman W. Sterling (Carleton):** Mr Chairman, I'm going to introduce a similar amendment but in different words, and it would be more appropriate to do so when the government presents its motion to strike this whole section and replace it. In other words, I'm going to amend the motion of the government on the overall amendment of section 9, so I withdraw my previous one.

**The Vice-Chair:** Thank you. We'll proceed to the government amendment.

**Mr Larry O'Connor (Durham-York):** I move that section 9 of the bill be struck out and the following substituted:

"Prohibition of smoking in certain places

"9(1) No person shall smoke tobacco or hold lighted tobacco in any of the following places:

"1. A hospital, private hospital, psychiatric facility, nursing home, home for special care, charitable institution, home, or place belonging to a prescribed class, as referred to in subsection 4(2).

"2. A pharmacy or retail establishment, as referred to in subsection 4(2).

"3. A school as defined in the Education Act.

"4. A private vocational school as defined in the Private Vocational Schools Act.

"5. A college of applied arts and technology, a university or any other institution of post-secondary education.

"6. A day nursery as defined in the Day Nurseries Act.

"7. The premises of a financial institution.

"8. An establishment where goods or services are sold or offered for sale to the public.

"9. A video or amusement arcade, as defined in the regulations.

"10. A self-serve laundry.

"11. A shelter or station used as part of a public transit system.

"12. A hairdressing establishment or barber shop.

"13. A place that belongs to a prescribed class.

"Exception, outdoor areas in certain places

"(2) The prohibition set out in subsection (1) does not apply to an outdoor area that is part of a place referred to in paragraph 4 or 5 of that subsection.

"Exception, private areas in certain places

"(3) The prohibition set out in subsection (1) does not apply to the parts of places referred to in paragraphs 2, 7, 8, 9, 10, 11, 12 and 13 of that subsection that are not open to the public.

"Exception, smoking areas in certain places

"(4) The prohibition set out in subsection (1) does not apply to an area set aside for smoking within a place referred to in paragraph 1, 4, 5 or 13 of that subsection, if the area is identified as an area where smoking is permitted."

This is an amendment to section 9, and I think it responds to many of the people who came to this committee and made presentations asking for other areas to be included.

**Mr Sterling:** As indicated just previously, I move that section 9 of the bill, as set out in the government motion just read, be further amended by:

—(a) adding the following paragraph to subsection (1):

"9.1 The common areas of an enclosed shopping mall, as defined in the regulations."

—(b) amending subsection (3) by inserting after "9" in the second line "9.1"; and

—(c) amending subsection (4) by striking out "5 or 13" in the third line and substituting "5, 9.1 or 13."

**The Vice-Chair:** Do you wish to speak further to the amendment to the amendment?

**Mr Sterling:** I withdrew my first amendment dealing with including shopping malls as an area where there will be some provincial regulation controlling smoking in these very public places to include it with the government's overall amendment to section 9. I believe the amendment put forward by the government to overhaul, so to speak, section 9 dealing with various different public places where smoking will be limited deals with the issue much better than the original section 9 in that it allows some exemptions for special areas to be set aside for people who might be smoking. It's a much more



logical method of doing it, and that's why I've deferred to them in terms of putting the enclosed shopping mall within the framework of the new amendment put forward by the parliamentary assistant.

I'd like to thank the government for accepting my amendment, and I do believe there will be some support on that part.

1020

If you could bear with me, Mr Chairman, I want to say early in the day, before we get into the heat of debate, that I was amazed to receive in the mail yesterday a piece of mail returned to me in support of Bill 71. This is from Eva Loraine Bryant of Mindemoya, Ontario, in Mike Brown's riding up in northern Ontario. This was sent out by me in 1986. Now, I don't want to blame the post office for this late delivery—

**Mrs Karen Haslam (Perth):** When was it postmarked?

**Mr Sterling:** Yes, there is a postmark. The postmark is actually this month, in 1994. Anyway, my point is that people who feel very strongly on this issue have been watching this debate for a long time, and I guess it's a lesson to all of us in politics that some people really don't ever forget what we do around here.

I did have about 30,000 of these sent back to me when I was pushing for Bill 71, which was the first controlling of smoking in the workplace and public places, but I want to thank Ms Bryant for her continued support. I suspect she might be watching today and I hope she appreciates the amendment I've just put forward here today to control smoking in public places.

**Mrs Haslam:** Wave, Norm.

**Mr Sterling:** One of my colleagues says I should wave, so how are you doing?

**The Vice-Chair:** Speakers to Mr Sterling's amendment?

**Mr O'Connor:** The government looks at this amendment as a friendly amendment. The anecdote is quite welcome, that there are really a lot of people interested in this issue. At times we get a little bit rambunctious in here, but we have to remember we are all very supportive of this legislation and the intention as we're bringing it forward. I appreciate Mr Sterling's working along with us, with a friendly amendment that would give us the ability to strengthen what he had suggested in earlier legislation he himself had introduced as a private member.

**Mr Dalton McGuinty (Ottawa South):** I'm going to support this amendment. It's a very good one. I have a question for Mr Sterling. We had the chance to speak briefly yesterday off the record. What would take place if, for instance, there are eating areas in some of our malls and there are people smoking in those eating areas? Would this permit that smoking to continue? If it does permit that to continue, I wonder about the effectiveness then, if I'm walking down a mall and there are people seated beside me and they're smoking but if I'm right here I can't smoke. I'm wondering about the practical implications.

**Mr Sterling:** I would agree with what your preference

would be on this. One of the reasons this was redrafted in this form is that perhaps the amendment I presented yesterday was a bit ambiguous about what areas it did or did not cover. Unfortunately, when you're trying to include an area like this which has many different kinds of configurations, circumstances, it's difficult to define that in black and white in the short period of time we have to deal with this bill. What I've done is defer to the government to make the regulations dealing with that.

I would hope that any cabinet dealing with it would be very strict in terms of defining which areas are included in this. It was certainly the intent of my amendment yesterday that common eating areas in common food courts would be part of the area covered by this regulation. That is my intent. I'm going to have to leave that up to the goodwill of the people who draft the regulation, and you and I as opposition members will not have input into that because of the system we're involved in. I have faith that the government will follow the intent of the original amendment I introduced yesterday.

**Mr McGuinty:** Further to that, I want to make it clear for future reference that the government should consider the absurdity that would arise if we were to ban smoking in shopping malls but in food courts you could smoke, meaning I could walk by a smoker who's seated at a table who is permitted to smoke but I, standing there, could not. If we're going to go on this, we've got to go the whole hog. That's my personal feeling.

**Mr O'Connor:** I appreciate what's been said here. Mr Sterling's persistence in this matter needs to be commended. I would like to offer him the opportunity as an opposition member, a third-party member, to have some further dialogue when we get to the regulation-making part around this, so we can actually have the opportunity to have a little discussion with you, Mr Sterling, at that point.

**Mr Sterling:** I'd be pleased to assist you in that regard.

**The Vice-Chair:** Any other speaker? You've heard Mr Sterling's amendment to the government motion. All in favour? Opposed? Carried.

Now, speakers to Mr O'Connor's amendment to section 9, as amended.

**Mr McGuinty:** I have a number of questions I wanted to raise or points to make.

First off, I had drafted as well an amendment which would've brought about the inclusion of an amusement arcade. I congratulate the government for moving forward on this one. If the focus here is to make it harder for young kids to get hooked on cigarettes, amusement arcades and video arcades are predominantly frequented by kids, and that's a good move. I also support the inclusion of the bus shelter.

To go back to item 1 with respect to hospitals—I'm not sure whether this came up before, but I just want to confirm this—does this mean there's no smoking allowed on the hospital grounds outside?

**Mr O'Connor:** Yes, except for designated places.

**Mr McGuinty:** That comes under subsection (4), right?

**Mr O'Connor:** Yes.

**Mr McGuinty:** The other concern I had was with respect to item 3, "a school as defined in the Education Act." I gather we're all in agreement here that smoking should be banned throughout the school grounds, inside the building itself and on the school grounds. I pulled the Education Act to look at the definition of "school," and I'm wondering if we should be using "school site," instead of "school."

"School" is defined in the Education Act. It talks about "the body of public school pupils or separate school pupils" and it talks about teachers and staff members, so it's making reference to the people, but "school site" talks about the "land or interest therein or premises required by a board for a school, school playground, school garden, teacher's residence, caretaker's residence, gymnasium, offices, parking areas or for any other school purpose."

I'm just wondering why we didn't use "school site" instead of "school." Those are two distinct definitions found in the definition section of the Education Act.

**Mr O'Connor:** I'd like to turn it over to Frank Williams, legal counsel. I think our intent is pretty well known at this point.

**Mr Frank Williams:** I'd like just a few minutes to look at this, if we could stand this down to give me five minutes to have a look at the act and then come back to it.

**Mr O'Connor:** While he looks at that, when we broaden it to the school site, I don't know whether that would include schools under construction as a school site but not where it's being used as a school as defined under the Education Act. I imagine there are many different reasons they looked at it and came up with this definition.

1030

**Mrs Yvonne O'Neill (Ottawa-Rideau):** I want to go back to yesterday's question about the exception in subsection (4) to determine who is going to determine the exception. Could we get some reading on that? I feel quite strongly that in certain of these locations, such as the post-secondary I referred to yesterday, there should be a real involvement and ownership on the part of the people who are using such a large facility as a post-secondary institution. If we want this bill to be successful, the actual owner-occupant should have some say, or certainly the municipal bylaws should have some input. I'm having some difficulty with being sure who is going to set the exception.

**Mr O'Connor:** I appreciate that concern. To get to the point we're at now in having this put in the legislation as it is, there was quite a broad consultation within the council of universities. We heard people coming to the committee who shared a different view with us. The Ministry of Education and Training, which has the responsibility for post-secondary institutions, has been involved in this process as well, and those people will be involved further as we go through the process to define regulations.

**Mrs O'Neill:** I think you understand part of my point,

but what I'm suggesting, and I go back to what I thought very powerful witnessing, that on each individual site there should be something in the regulations that indicates that the people who live there or work there are involved and have input. Otherwise, this is an imposition from Queen's Park, which nobody likes.

That, I think, is one of the reasons the workplace health and safety smoking provisions have not been as successful, because they haven't had continual dealing with that at the actual site of the workplace. I remember when they first came in through the Ministry of Labour and there was a struggling to come up with something legitimate. Now the enforcement in many of those locations, as you know, has really fallen off. If we are only going to have imposition from Queen's Park, I think that's what will happen. If people have to deal with this through the workplace health and safety committee, deal with it through their student councils or their student governments, there will be much more ownership. I feel quite strongly about this.

Hopefully, the regulations will indicate that there will be the obligation on the part of the governance body. Whether that be a school board, whether it be a municipal council, whether it be a retail council, there should be some ownership developed onsite on this policy.

**Mr O'Connor:** Part of the ongoing process as we go through this, beyond the legislative role we are dealing with at the current time, will be the education role, and that's an important role. There will be many people involved in that process of education. Actually, a large number of the presenters who have come before the committee have been involved in the education role that goes beyond that.

I think what will be prescribed in the regulations—and we'll talk to people as we draft those regulations; it won't be done here at Queen's Park by itself—is the classes of places within these types of locations. At the same time, what Mr McGuinty put forward as a concern was that we may prescribe some of these places a little tighter than what is in the other parts of the community. For example, when we talk about a restaurant on a campus, are we going to prescribe something there that's going to be tougher than what is prescribed for the rest of the industry? And that's not the case. We're conscious of trying to maintain a level playing field. At the same time, there is the need for the consultation you're talking about.

**Mr Sterling:** When I read this legislation and the sections dealing with who's going to set out these smoking areas and who's going to be responsible for that, I read it in context of the experience of the bylaws in some of the municipalities which have made bylaws, particularly thinking of restaurants. My understanding would have been that the government's function would be to make regulations, for instance—I'm just taking this off the top of my head—to prescribe minimums or maximums for smoking areas in various kinds of establishments. Then it would be up to whoever controlled those premises to comply with those regulations that were set down. That would be the way it would fall out.

My question, though, that evolves from the discussion Ms O'Neill brings up, is who would be responsible for



ensuring that the minimum for, for instance, non-smokers would be abided by? In other words, if it said three quarters of these premises had to be for non-smokers, who's going to enforce that? Perhaps you can help me, Mr O'Connor. Will it be the health officer, or should that be designated in the legislation? When you're introducing new regulations in society, I think it's much better if you identify who is going to carry the can on this so in fact they know that's their responsibility.

**Mr O'Connor:** A valid question, Mr Sterling. There are two elements to this. Part of it would be that the owner and operator of the facility would have some responsibility in this—we had some discussion about that yesterday—and of course the public health unit would have some responsibility in this area as well. Some of that is shared, and the ability is implied in the legislation. The owner-operator, I would think, would then comply.

**Mrs O'Neill:** Are you suggesting that the minimums and maximums, as Mr Sterling has just mentioned, are foreseen in the regulations? This was the way it was, if you remember, with the Ministry of Labour when this first came out in—what?—the early 1980s: 25% had to be smoke-free, I think it was. There were minimums and maximums set. I think it's become very loose now in its enforcement. Is that what you're anticipating?

**Mr O'Connor:** At this point, what we would be establishing would be the minimum standards right across the province for non-smoking areas, and then the municipalities can designate further than that. Of course, any organization can always decide to set its own policy. I used the example of the Mount Albert Lions Club up my way. A new facility opened up, and their policy is that it's a non-smoking facility. It's a brand-new facility and they want to keep it clean.

**Mr Sterling:** One of the questions I had on this section is one there's a lot of debate about. I wonder why the government didn't include it, and I was somewhat tempted to include it as another public place: the whole area of arenas, where young people are inhaling, because of their exertion, at a much more rapid pace than people who are not exerting themselves physically. I think I have part of the answer, the reason being that it's difficult to describe what is or is not an arena. If that's the case, perhaps we could move to amend this section in a similar fashion to the way we did with shopping centres, ie, work out the details of how we define what is included in the arena or what is not included.

I'm particularly concerned about the areas where children are exposed, and particularly where they are physically exerting themselves: in a gymnasium, when they're exercising; when they're skating, roller skating, playing ball hockey or whatever. Some of our arenas across this province don't have non-smoking provisions. A lot do, a lot of municipalities have taken those steps, but some don't, and I don't think the children who are occupying those facilities should be subjected to secondhand smoke. Perhaps you could answer why this wasn't included.

1040

**Mr O'Connor:** I appreciate your concern. We're all concerned about the ETS. We do have the ability in paragraph 13 to move that way within regulation. It's

something that will definitely stir up community debate, and I think the wish here is that the community should be involved in that process as well. At some point down the road we do have the ability to do that as well, but it's something there needs to be some community debate on, and hopefully the right decisions will be made.

**Mrs Haslam:** That's what I wanted to know, if it could come under "a place that belongs to a prescribed class." There will always be something we can add, and my concern is that we'll come up with another one and another one and another one and we'll be here for a week discussing what new things. We could say bingo halls, for instance, should be added into the legislation too, but they weren't part of the original discussion. I'm sure there would be a lot of input from people out there on that particular one. I was going to ask if what Mr Sterling is suggesting could be looked at along with some other ideas and whether that would fall under 13, "a place that belongs to a prescribed class."

Also, we talked yesterday about subsection 9(4), "exception, smoking areas in certain places," and I'd like clarification. For a couple of minutes we talked about whether the area is identified as an area where smoking is permitted, and there was the question about who says that. Let's go back to the mall question. If the mall says, "We are going to designate a smoking area in the cafeteria eating area," provided the criteria in the regulations are not such that they negate that, does that take precedence? Or, if the municipality has set criteria for where smoking is permitted, is that what is governing here, or will there be criteria in regulations that say to these places, like the mall, like the hairdresser, like the video arcade, where smoking is permitted?

If you go back to "if the area is identified as an area where smoking is permitted" in 9(4), it's 9(1)4, the private vocational school, (1)5, the college, and (1)13, "a place that belongs to a prescribed class." A prescribed class might be the arena. I'd like some clarification on how you would look at who identifies an area where smoking is permitted.

**Mr O'Connor:** I guess you're testing to see how well along we are with some of the regulations, and also how up I am on some of this at this point.

First, to help illuminate some of what's happening in terms of recreational places, and this may help Mr Sterling as well, the Waterloo health unit has received a grant to develop what can be used for municipal bylaws around recreational areas and community centres. That would be bylaws, not necessarily municipal. Of course, if it's a private place the operator of such a place can designate.

When it comes to our legislation, if the municipal bylaw goes further than our legislation will, the municipal will take precedence. If the owner of an establishment had a policy in place and that policy is weaker than the municipal bylaw, the municipal bylaw will come in place. If our legislation is stronger than either of the other two examples I've used, ours would take precedence. It's always the stronger offering more protection for the non-smokers that will take precedence.

**Mrs Haslam:** It doesn't mention regulations, and



that's why I'm asking. It just says exemption "if the area is identified as an area where smoking is permitted."

**Mr O'Connor:** Good question. There will be an amendment that I'll be moving very shortly to 10 that will clarify that, I hope.

**Mrs Haslam:** Okay. I haven't seen that one yet.

**The Vice-Chair:** Any other speakers? It's been suggested that Mr O'Connor's motion to amend section 9 be stood down for a report from Mr Williams at a later time, is that correct?

**Mr Williams:** I've spoken to Mr McGuinty. I'm wondering if we should wait till he comes back into the room. I think he's satisfied with the definition the way we have it now crafted, but I would rather wait till he's here before I make any further comment.

**The Vice-Chair:** Is it in order to recess for a few moments?

**Mrs O'Neill:** I don't know how long he's going to be, because he indicated what I should do about the next amendment to come forward.

**The Vice-Chair:** If you're ready to proceed with the Liberal amendment to the government's amendment, we could deal with that now.

**Mr Sterling:** If Mr McGuinty is going to be gone for a considerable period of time, we should press on.

**Mrs Elinor Caplan (Oriole):** He just went out to make a phone call.

**Mrs O'Neill:** I don't think he'll be too long, but he didn't tell me to tell us to wait on this one.

**The Vice-Chair:** Mr McGuinty has returned. We were wondering about your amendment to section 9, paragraph 8.1. Did you wish to present that?

**Mr McGuinty:** I'm asking if we could stand it down at present, Mr Chair. I might also indicate that I had the opportunity to speak with legislative counsel regarding the definition of "school" and I'm satisfied that it is all-encompassing and will cover all the grounds.

**The Vice-Chair:** Will you be proceeding with the Liberal amendment, paragraph 8.1?

**Mr McGuinty:** Not right at this time.

**The Vice-Chair:** To stand it down, it's in order to move it and then stand it down, if you're going to proceed with it later.

**Mr McGuinty:** That doesn't preclude me from withdrawing it subsequently, Mr Chair?

**The Vice-Chair:** No. It would be in order to do that. Move it now, and we'll stand it down along with the government's amendment.

**Mr McGuinty:** I move that subsection 9(1) of the bill, as amended by the government motion, be amended by adding the following paragraph:

"8.1 The premises in which a member of the College of Physicians and Surgeons of Ontario practises medicine."

**The Vice-Chair:** And you wish that stood down at the present time?

**Mr McGuinty:** Yes, please.

**The Vice-Chair:** And it's agreed that the government amendment be stood down as well at this time.

**Mr O'Connor:** No. I think we're ready to move forward with it.

**1050**

**The Vice-Chair:** Any further speakers on Mr O'Connor's motion to amend section 9? If not, all those in favour of Mr O'Connor's motion to amend section 9? All in favour? Opposed? Carried.

There is a government amendment to section 10.

**Mr O'Connor:** Yes. I move that the bill be amended by adding the following section:

"Smoking areas

"10.1(1) The person who owns, occupies, operates or maintains a place referred to in paragraph 1, 4, 5 or 13 of subsection 9(1) may set aside for smoking an area within the place and identify it as an area where smoking is permitted, if the prescribed criteria are met.

"Area that does not meet criteria

"(2) A person described in subsection (1) shall not identify an area as an area where smoking is permitted if the prescribed criteria are not met."

That just helps to clarify some of the concerns we heard from Ms O'Neill and Ms Haslam.

**Mr Sterling:** I have not read this motion, Mr Chairman, but I want to amend the government motion. I have discussed this briefly with legal counsel and he agrees with me that it's appropriate.

I move that section 10.1 of the bill as set out in the government motion be amended by amending subsection 10.1(1) by inserting after "5" in the second line "9.1."

In other words, I've inserted among the numbers 1, 4, 5 and 13, also 9.1, which is the shopping centres.

**Mr O'Connor:** That's a friendly amendment. It brings in his other concerns around the mall.

**The Vice-Chair:** Any further speakers? If not, all members in favour of Mr Sterling's amendment to the government's amendment? Opposed? Carried.

Now, Mr O'Connor's amendment as amended. Any discussion?

**Mr Jim Wilson (Simcoe West):** Perhaps the parliamentary assistant could briefly give us an outline of some of the prescribed criteria the government is contemplating.

**Mr O'Connor:** At this point, a person who owns a place or maintains a place may have a place that is closed off, that's used only for their purposes. It may be an area where they have an office that's not a public place but just a place they maintain for their own purposes, which could be part of something designated smoke-free. There could be an exception there that doesn't take away from the prescribed criteria.

**Mr Sterling:** There may be contemplated in this section criteria such as many people have desired in the past and want, that any smoking area, for instance, be separately ventilated to the outside or whatever.

**Mr O'Connor:** That's right.

**Mr Sterling:** I have two questions around the section,

and maybe legislative counsel can help me here. First, can you prescribe different criteria for the different classes we've included? In other words, you might prescribe separately ventilated for—and I'm just picking these out of the air—1, 4 and 5, but not 9.1 and 13. Can you do that?

**Mr Williams:** It's possible. There might be different criteria for different types of places. That's correct, depending on the type of premises.

**Mr Sterling:** I think it's necessary to have that kind of flexibility, because you're talking about different kinds of enclosed areas and that kind of thing. Can you, under this section, prescribe different criteria for buildings that are built, for the sake of argument, after January 1, 1995, and those before?

**Mr Williams:** I hadn't thought of it from that perspective, but I don't see why not.

**Mr Sterling:** It's my view that it would make a lot of sense for the government to move quickly in prescribing, for instance, separate ventilation for anything that is going to be constructed in the future, so that people will know when they're getting into building a new hospital, a new shopping centre etc, if they are going to provide a smoking area, they're going to have to provide separately ventilated areas. That's my own feeling on it.

I don't think you can move as quickly, or you may decide not to move as quickly, in going back to existing buildings because the cost may be prohibitive in terms of providing that same standard for established buildings as it would be for new. You can usually do something much more reasonably if it's not renovating an existing premise.

I'm satisfied that the section is necessary and we will be supporting it, but I would hope the government looks at moving quickly to have fairly stiff criteria for smoking areas, particularly in new buildings.

**Mr O'Connor:** Thank you for your support, Mr Sterling.

**The Vice-Chair:** Any other speaker? If not, those in favour of Mr O'Connor's motion to amend section 10, as amended? All in favour? Opposed? Carried.

Does that deal with section 10 in entirety? We have approved the government's motion to amend section 10, so it's the new section 10 that's approved. Mr Williams, would you like to assist?

**Mr Williams:** I was just going to suggest that you might want to move that section 10 be carried. There's no amendment to section 10. Section 10.1 is an addition to the bill.

**The Vice-Chair:** Then section 10, as printed, is still in order. That's what I was confused about. Fine. That clears it up.

Section 10. All those in favour of section 10 in the bill? Opposed? Carried.

Section 11: There's a government amendment.

1100

**Mr O'Connor:** I move that section 11 of the bill be amended by striking out "or that imposes the greater penalty" in the fifth and sixth lines.

**The Vice-Chair:** Do you wish to comment?

**Mr O'Connor:** The current wording of the bill is "the provision that is more restrictive of smoking or that imposes a greater penalty prevails." If one piece of legislation was more restrictive of smoking and the other had a more restrictive penalty, the enforcement could be compromised.

**Mr Jim Wilson:** It would be a larger penalty versus a more restrictive smoking rule.

**Mr O'Connor:** Yes, and it's the recommendation we've received from the Attorney General's office.

**Mr Sterling:** I support this. You could have a much less restrictive policy or bylaw with a huge penalty. Then you're caught in the conundrum of which law really supersedes the other, the one with the bigger penalty or the one with the more restrictions. Therefore, I think striking out the penalty is the proper way to go.

**The Vice-Chair:** Does anyone else wish to speak? If not, those in favour of Mr O'Connor's motion to amend section 11? All in favour? Opposed? Carried.

Those in favour of section 11, as amended? Opposed? Carried.

Section 12: All those in favour of section 12? Opposed? Carried.

Section 13: There's are government motions to amend.

**Mr O'Connor:** I move that subsection 13(4) of the bill be amended by striking out "normal" in the third line and substituting "regular."

Would you like me to move the further—

**The Vice-Chair:** No, let's deal with this one. Any comments regarding this one? Do you wish to explain?

**Mr O'Connor:** Again the intention here is clarification for consistency purposes requested of us by the Attorney General's office.

**The Vice-Chair:** Any questions or comments? All those in favour of Mr O'Connor's motion to amend subsection 13(4)? Opposed? Carried.

Further amendment?

**Mr O'Connor:** I request that we vote on section 13 subsection by subsection, because there is one I would like to have changed slightly.

I'd like to move that section 13 of the bill be amended by adding the following subsections:

"Same, vending machines

"(8.1) An inspector conducting an inspection may open a vending machine that is operable or is in a place to which the public has access, and no person is liable for damage done to the machine in connection with the opening.

"Seizure and forfeiture

(8.2) The inspector may seize any tobacco and money found in the machine; the tobacco is forfeited and shall be dealt with as the Minister of Health directs, and the money is forfeited to the Minister of Finance."

This is just enabling power to allow the inspector permission to open these machines.

**Mr Jim Wilson:** But I think the power given to the



inspector under this amendment is excessive, in fact draconian, given that you're taking someone's property. Under the powers of this amendment the inspector could take a crowbar, totally wreck the vending machine and make it useless to the operator of that machine. Although the government has decided to ban tobacco vending machines everywhere in the province, the last hope for some of these people would be to sell those machines to other jurisdictions that still allow them. The inspector can totally wreck the vending machine, and the government has put in this draconian phrase that "no person is liable for damage done." That's bloody awful, and I think it's excessive when you're dealing with somebody's vending machine.

I would like a comment from the parliamentary assistant. Given that they've refused the PC amendment to allow compensation to these vending machine operators that you're putting out of business and now you can go around destroying their machines if need be, I think that's very excessive.

**Mr O'Connor:** I appreciate your concerns, Mr Wilson. The fact is that at this point it would be a prohibited machine. We hope that by spelling out the extended time frame for people, they will know when this legislation is coming into place so that they've got something they can work towards to have this machine removed.

It would be certainly the intent of the government and the inspector that they would approach the owner and the operator of this machine and ask them to open it. The key here is that it would be after the deadline, and these machines would be a prohibited machine at that point anyway. I hope that through a very public process we'll be able to identify to these owners and operators of these machines that they have a machine that is no longer going to be allowed in the province of Ontario.

**Mr Jim Wilson:** If I might have a supplementary, Mr Chairman, it seems to me that yes, you're dealing with a machine that's prohibited under this section. But when somebody steals a bicycle and the police find the stolen property, they don't destroy the bicycle. They try and find the rightful owner and give it back in good condition so the little boy or girl will get their bicycle back. In essence, you've got property that's the subject of a crime, and you don't go around destroying the property. Why can't you treat these vending machine—I just think it's extremely excessive to give a government employee the right to go in and smash up a vending machine.

**Mr O'Connor:** The key here, Mr Wilson, is that at that point we have a machine that has tobacco that shouldn't be sold through that venue—

**Mr Jim Wilson:** But you don't know that till you open the machine and you've already destroyed the machine.

**Mr O'Connor:** The purpose of this section is that the machine can be opened. Hopefully, the owner of the machine will have complied already, but in the case where they haven't been able to comply, the inspector would be able to approach the owner of the machine and tell them this machine is prohibited and then remove the tobacco products.

The key here is that we're trying to work with these people, not work against them. We're going to work with them as much as we can. In a situation where we have a machine in contravention, we have to have the ability to see whether the machine is illegally selling these tobacco products.

**Mr Jim Wilson:** What comes first, though? Are there any probable grounds? What if you open the machine and there's nothing in it and you've already wrecked it? It is quite possible. Some of these vending machine people aren't going to go to the expense of retrieving their vending machines, possibly, for quite a while. The one in Orillia particularly will be out of business. I don't know how in the world they're going to have the money to go around retrieving their machines.

You may find some sitting around in beverage rooms who think they're conforming to the federal act of Canada and aren't aware of your particular act. You're going to go in and wreck their machines without any probably grounds, without knowing whether there are any cigarettes in them or not. Does the inspector at least have to buy a pack out of the machine first to know that there was anything in it?

**Mr O'Connor:** The key here is that, first of all, unlike the federal government's ban in the areas it has prescribed, which is everywhere except licensed premises, we are giving them a date. They'll have a date they'll know they're going towards. I don't think there's going to be a cigarette vending machine operator in the province who isn't going to know that on December 31 their machines will be prohibited in the province of Ontario. It's that rare exception that may be the case.

**Mr Jim Wilson:** Well, obviously you're preparing for some sort of exception or you wouldn't ask for these powers in the act.

1110

**Mr O'Connor:** If there were a way the machine could be made inoperable by the owner of the machine, if it was on the premises, and it could be shown to be inoperable, I guess at that point they wouldn't be in contravention of the law if it were inoperable. And it can be made inoperable by the owner of the machine.

**Mr McGuinty:** I have concerns about how far-reaching the section is. Why is it necessary to open a machine?

**Mr O'Connor:** How else will you know whether there are tobacco products in there? What we're dealing with is a machine whose whole purpose is the dispensing of tobacco products, which is illegal.

**Mr McGuinty:** Maybe I'm missing something here, but if I've got a vending machine and I want to sell cigarettes, how am I going to let people know there are cigarettes in there without making that apparent?

**Mr O'Connor:** Some machines are designed in a fashion that you can't tell whether there are tobacco products in them. If we have an operable machine sitting there without a way of knowing whether there are tobacco products in it, that machine is in contravention of the law.

**Mr McGuinty:** How would somebody know there are

cigarettes in a machine if that wasn't advertised somehow on the outside of the machine?

**Mr O'Connor:** In many cases, there's no way of knowing whether there are tobacco products in that cigarette vending machine until you start feeding your coins into it. After December 31, that machine is going to be prohibited, and you don't know whether that machine contains the tobacco products.

The key here is that what we've got is an extended period of time, given the concerns we've heard, of December 31. We've got a date laid out. The federal government has banned vending machines right across the country in every place except licensed premises, which caused a problem here in the province of Ontario. After hearing from many witnesses saying young people do have access to these licensed premises and we have a problem with that here, and then hearing the concerns that these operators of these machines want to comply with the law and they're trying to comply with the federal law, that never even gave them a date—they had suggested that the date might be July 1 and that's when the law would be proclaimed—what we're giving them in this legislation is a date to work towards.

I don't think these operators are going to be out there trying to break the law intentionally for any extended period of time, because what we've got here is an opportunity for them to see. They've got till December 31, unlike the legislation that came out of Ottawa that didn't tell them when.

**Mr McGuinty:** I'm not disagreeing with you.

**Mr O'Connor:** In fact, the ads went in the newspaper telling them they were banned after they had been banned. We're trying to do this in a fashion that's going to be more open.

**Mr McGuinty:** With the greatest respect, I don't see how it's in any way productive to keep referring to what's happened in terms of the timing of the federal legislation in so far as my question's concerned. We have to presume that the people who own and operate these machines now will be innocent on January 1, 1995. If I'm an inspector and I have two options, to put some loonies in the machines or break it open with my crowbar, I think I should be putting some loonies in the machine. That's in keeping with the presumption that the person who owns that machine is innocent.

Okay, you can't tell whether there are cigarettes packages inside. Why wouldn't we put some loonies in the machine? Why wouldn't we require that the inspector have reasonable grounds upon which to believe there are cigarettes inside the machine before you go in with a crowbar and cause damage?

**Mr O'Connor:** Following some of the assumptions you've made, what would happen if the inspector didn't have these powers and the inspector put the loonies into this prohibited machine in the province of Ontario and out came the cigarettes?

**Mr McGuinty:** Then you can use the crowbar.

**Mr O'Connor:** So you're saying this is a good amendment if it spits out—I would think the inspector's going to use some reason, as you're suggesting here.

**Mr Jim Wilson:** Oh, come on. Not always.

**Mr O'Connor:** I would think that before the inspector is about to go and take what appears to be an operable machine, he's going to go to the owner of this machine even before that point.

**Mrs Caplan:** But you don't require in the amendment the concept of reasonable grounds. If you had the test of reasonable grounds, what Mr McGuinty is saying would follow. Your amendment gives them the right to break open the machines without examining first, without having reasonable grounds. In jurisprudence in Ontario, the presumption of innocence is a basic fundamental of our justice system. I think we all agree that if the machine contains cigarettes you should have the power to open and remove them, but there should be reasonable grounds before you do that.

**Mr McGuinty:** I agree with my colleague. It's fine to give the inspector this kind of power, but there has to be some kind of general limitation to ensure that it can't be abused. For instance, this wording doesn't even say it has to be a cigarette vending machine. It just says, "An inspector conducting an inspection may open a vending machine." There's no definition of "vending machine" in the definition section of Bill 119, so we haven't even confined it to a cigarette vending machine, first of all.

Second, I think there should be something, and I hope the parliamentary assistant is open to a friendly amendment on this, which requires that the inspector have reasonable grounds to believe that the vending machine contains cigarettes. It's as simple as that.

**Mr O'Connor:** Mr McGuinty, in some of the other types of machines you refer to, most often they display the product, usually through glass. Vending machines whose sole purpose is to sell cigarettes would be the machine we're talking about, and they're pretty standard in what you see. The key here is that when the inspector feels this machine, an obvious cigarette vending machine, may contain cigarette tobacco products, an operable machine that could be problematic—it's in contravention of the law. I'll have to check this out with legal counsel, but perhaps we could amend it to read something like that: when conducting an inspection, "where an operator or owner refuses to open the vending machine, and the inspector has reasonable grounds to believe that tobacco products are in the machine, may open the machine." I think this would address your concerns.

**Mr McGuinty:** Very much so.

**Mr O'Connor:** I'll have to ask legal counsel if—

**Mr Williams:** You got it right, subject to legislative counsel correcting my—

**Mr O'Connor:** We may have to stand this down so we can rewrite it to include that and get some other advice in case we have some problems with that. That would address your concerns?

**Mr McGuinty:** Yes, it would.

**Mr Sterling:** I was going to move an amendment. I defer to legal counsel, but my amendment would have added, after the word "opening" in subsection (8.1), "if tobacco is found therein." In other words, you only give freedom from liability if in fact the inspector finds



tobacco in the machine. If he doesn't find tobacco in the machine, then the owner of that vending machine is presumably entitled to compensation for the damage done.

Surely to God we're not saying that an inspector goes in and acts either rationally or irrationally, breaks open the machine with a crowbar because the owner is not there or the key isn't there or whatever, and it was candy bars, not tobacco, and they can walk away and say, "Sorry, you're out of luck. I'm covered by the legislation." I don't think we should do that.

I don't know which is preferable, the reasonableness test or—I'm concerned about the liability for damage done. Even if he thinks he's reasonable or has reasonable grounds, I don't think the crown should be absolved of paying for the machine.

1120

**Mr Williams:** I would prefer the amendment I suggested to the parliamentary assistant, for the following reasons. The problem with the motion you're moving, Mr Sterling, is that you could get into the conundrum where, as you say, you go into a premises where the owner or operator isn't there, so you have nobody you can ask. You stick the loonies in the machine and cigarettes come out, so you've got reasonable grounds to believe that there's tobacco there. You open the machine and you find you got the last pack. That puts the inspector in a rather awkward position.

I think there has to be protection for the inspector as well. If he opened it and there was no tobacco, then the inspector would be liable. That's the problem I have with that. I'd rather leave it on reasonable grounds to believe there's tobacco, and that would be the grounds you got from putting the loonies in and having the tobacco package come out of the machine.

**Mr Sterling:** If you put the loonie in and get the tobacco out, why would you break open the machine? You've got your evidence.

**Mr Williams:** The point is that you'd want to remove the tobacco from the machine so nobody else has access to the machine and can get cigarettes.

**Mrs Haslam:** They can't see through machines. That's what I was asking clarification on, because I'd rather go with the reasonable doubt. If we can get a friendly amendment that says "reasonable doubt after inspection" or after they are sure there's tobacco in there, I would like to see that.

My questions were around the same idea. If an inspector comes in, if he drops loonies in and gets materials, if he asks the operator or owner to open it and the operator or the owner doesn't open it, then he has reasonable grounds to break it open. I would imagine that is the situation inspectors would be in. We're talking public health inspectors.

I think of the police, who say to you: "I have reasonable grounds to suspect there's dope in the trunk of your car. Open it up." The person says, "No, I won't." Then they go ahead and open it up and they aren't held liable, is my understanding; they aren't held liable for the damages.

I think we should allow the same situation. Although

they're not police, they are inspectors, and we should be giving them the grounds and the reasonableness to look at this type of machinery and not hog-tie them. I would rather err on that side and go with the original amendment Mr McGuinty was talking about, looking at reasonable grounds, and if there are reasonable grounds and the owner or operator will not open the machine, they certainly have the right to open that machine.

I don't anticipate the public health inspectors travelling around with a crowbar in their hands, either. I would imagine they will be doing inspections. They will have reports of a machine from someone in the public. They will then contact the owners and say, "Is this machine operable or not?" I find public health inspectors do their job well, and I wouldn't anticipate that they're going to go in and damage a machine unnecessarily.

**Mrs Caplan:** I think this is a really important debate. As we give inspectors powers, we have to be very careful as we draft laws that we don't assume behaviour that is going to ensue. Anything we can do in legislation that is prescriptive about the kind of behaviour we expect, especially when we are limiting rights of the individual and the public and doing that in the public interest—it's still very important for us not to overrotate and to give powers to inspectors which are going to impact on our civil liberties in a way which was unanticipated or unintended as a result of the way we've drafted legislation.

While we may sit around this table—and many of us have had experience with public health inspectors—and feel that by and large they do a very good job, I don't think we can assume a certain behaviour in the future if they have a power in legislation that we have given to them.

I think the amendments that have been suggested by Mr McGuinty are very important, because they will protect the rights of the individual and they will ensure appropriate behaviour by inspectors who are being given unprecedented powers in this legislation. I think we have to do so cautiously and carefully and not assume anything which we can prescribe, so that the result will be as intended. I feel very strongly about that. I know our job as legislators is often to intrude on individual rights in the name of the public interest, but I think we must be careful, very careful, to do this in a way which is as thoughtful and careful as possible. So I encourage support for Mr McGuinty's amendment, which would require reasonable grounds before you could have the powers of, really, search and seizure.

**Mr Jim Wilson:** This is tag-team theft on amendments, I think, between Caplan and McGuinty and O'Connor, but none the less, it was my idea. Having said that, I think we also have to have an onus of liability on the inspector. I want to follow up on Mrs Caplan's comment, because I agree: You can't assume the behaviour of health inspectors.

We owned a general store for several decades in the family, my grandfather and father and his brothers. My grandfather used to shout, yell and threaten the health inspector out of his store. He always found them so unreasonable. It was not unusual to have a very bad

relationship between the local health inspector or the local liquor inspector and businesses.

MPPs should be aware that we get complaints from time to time about the enforcement by inspectors in premises in our ridings and we're asked to take a reasonable look at what's going on. Because we can't interfere directly with their powers, we often are called upon to write the minister to review what's going on.

I agree that you just can't assume how these people will behave. Many of them have never run businesses, and they come in and have a public health bias. When you're dealing with a butcher shop area, they may ask for things that are extremely unreasonable and difficult for the business person to do or the butcher to do. They'd never been a butcher, so as we found in our business, they didn't understand that it's damn near impossible to clean your knife after every steak you cut and there's a lot of to and fro. Fortunately, in our public health acts now, there is some flexibility for inspectors to hear out the business operator's side of things.

For instance, I can remember a requirement that public health inspectors thought up to wear mesh gloves. Well, it turned out that mesh gloves, when you were butchering meat, were more bloody difficult and caused more accidents, but some bureaucrat thought this was the way to protect the hands of workers. It turns out you ended up slashing your wrists because the blade would go up the mesh and up to your arm and then you had to wear the things up to your underarm. It's an example of a very ridiculous thing thought up somewhere along the line by someone who had never been a butcher.

**Mrs Caplan:** But were they smoking while they were cutting the meat?

**Mr Jim Wilson:** Actually, in those days you probably did smoke, and God help your hamburger.

I just wouldn't assume behaviour at all, because we often appoint people to these positions whom it takes time to teach that you also have to put your feet in the shoes of the people you're inspecting so you understand their point of view.

**Mr Sterling:** Mr Chairman, I'm going to put forward my motion, notwithstanding what legal counsel has said. I'll tell you why I'm going to put it forward, that generally speaking, when you compare the resources of the people who may own a candy bar machine or whatever to the resources of the government of Ontario, there is really nothing there. That somebody would break open a machine after they had taken out one pack of cigarettes and there would be no more there—well, the chances of that happening are about one in a million.

Maybe the amendment isn't perfect in protecting the government, but compare who we're protecting here, either the poor guy who owns a candy bar machine which is mistakenly opened by an inspector who breaks the machine—why should that inspector be protected, who may have the time to go to court to argue that he had reasonable grounds, or why should the government be protected from compensating the poor guy who owns the candy machine that was busted by the health inspector?

1130

There has to be a huge argument that this is going to inhibit a health inspector from opening the tobacco machine, and I don't think it would. If he thought there was tobacco but there is a mistake—the likelihood of compensation in these kinds of things is so remote, but I think it's important that we don't give in this section what to me is a signal to inspectors that, "You go in, you take a crowbar to a machine, regardless of what it is, and you're protected, and we're protected, in legislation."

That's what the words in this amendment say. If you read them and you are an inspector, you'd say: "I've got a lot of power here. I can walk in and I can wreck this machine." I'm talking about the poor inspector. I'm not talking about the majority of them. I'm talking about the odd inspector you get who becomes a little authoritarian and takes matters further than he or she should.

So I move that subsection 13(8.1), as set out in the government motion, be amended by adding "if tobacco is found therein" after the word "opening" in the last line of subsection (8.1).

**The Vice-Chair:** That's your amendment, Mr Sterling, adding those words? Mr Sterling has moved an amendment to Mr O'Connor's motion.

**Mr McGuinty:** Could I have the parliamentary assistant read the amendment he read earlier, just so we're clear about what we're dealing with here?

**Mr O'Connor:** The amendment I read earlier hasn't been amended. That was just a suggested amendment, so I haven't actually amended my amendment at this point. Before I do that, probably the easiest way, in the light of what you were thinking, and giving legal counsel a chance to rewrite it, would be to withdraw my amendment and re-enter it with the suggestions you've made. That's where we're at, at this point.

**Mr McGuinty:** My concern would be that the wording contain something to the effect that you've got to have reasonable grounds. If he has reasonable grounds, the inspector and the government should be absolved of any liability. That's the critical test. If he didn't have those reasonable grounds, he or she is in trouble, and the employer, the government, is in trouble. That's the usual rule that's applied in these cases, certainly with respect to policing. That's not a test that is easily met. If an inspector has information from a number of people that this machine contains cigarettes—it may not even be plugged in at the time—as long as that information is reliable, we have to allow him that authority. I don't see any reason to deviate from the usual rule, which is as long as you have reasonable grounds. That's the test to be met, that has to be satisfied. If it's not, you're in the hot seat.

**Mr O'Connor:** Mr Chair, to further help with what Mr McGuinty's trying to add here, and I appreciate his support, I'd ask legal counsel to—

**Mr Williams:** I've had some discussions with legislative counsel and she's now trying to put some words together. I don't know how you want to do this, move on to another section or continue the debate on this issue.

**The Vice-Chair:** We have additional speakers, so perhaps we could continue.



**Mrs Haslam:** I would agree that's the kind of amendment I'd be looking for to support.

I'd like to know for my own interest, who pays, for instance? My concern is that you leave an inspector out to dry if that happens. I'd like some clarification on this. If he has reasonable grounds and that's proven, that's fine, but if, on the other hand, he goes in and no tobacco is found, who pays for that? Is it himself or is it his employer as the public health unit or does it come back to the government? I need some clarification on that before I'm ready to say okay, let's go that route, because I'm not in favour of that route. I would like to see it more along the lines that reasonable grounds must be adhered to.

**Mr Sterling:** As far as I can determine in terms of what happens here, I would have to see the wording of what we're drafting. But my concern is that whether there are reasonable grounds or not, what we're talking about here is not a major, major offence like dealing with drugs, dope or whatever. If, even with reasonable grounds, there's no tobacco found in it, I don't believe the citizen should pay. I guess this is more to do with victim rights or whatever it is.

**Mrs Haslam:** What is the comeback? If there's reasonable grounds that I am smuggling bicycle pumps and I say, "Sorry, I don't have the keys and I'm not going to open this; I don't have any bicycle pumps in there," and they open it, damage my lock, and there are no bicycle pumps there, what's my comeback? Nothing.

I'm saying this should be handled in the same way as whatever the rights are I have as an individual in other jurisdictions or under other legislation. I am not about to say a public health inspector has less rights than our own police force or that I have more rights because I have a tobacco vending machine than if I had a trunk that was tried open and I didn't have bicycle pumps in it. That's what I'm asking legal counsel for clarification on.

As an individual, in the case where I have no bicycle pumps, where my trunk has been opened and they say, "Oops, sorry, Karen, no bicycle pumps," what is my comeback on the police or the customs people who open up my trunk and there's damage? Is it a court case? Do I have to sue? In which case, that should be what we look at in this legislation.

**Mr Williams:** I'm certainly not an expert in this area, but my gut feeling is that if there's not reasonable grounds, whether it's a police officer or an inspector in this sort of circumstance, there would be some liability. Normally, I would assume that the liability would be borne by the employer of the police officer or the inspector. By adding some phrase that refers to "reasonable grounds," it would give the individual some legal rights if in fact there were no reasonable reason to break into the machine.

**Mr Donald Abel (Wentworth North):** What if there were reasonable grounds?

**Mr Sterling:** That's the problem I'm faced with. Let's say the reasonable grounds are that somebody said, "I got tobacco out of that machine."

**Mrs Haslam:** Or "I saw somebody get it."

**Mr Sterling:** The poor guy who owns the candy machine isn't even party to any of this. He's absent from the premises. The health inspector says: "My reasonable ground was the fact that this outstanding citizen said they got tobacco. I opened it up, and there's no way tobacco could be sold. I broke the machine. Under this section I don't have to pay." Why do we have "no person is liable for the damage to the machine"? Is that a normal section you put in every kind of section like this?

**Mr Williams:** If you don't put something in with respect to liability, then the inspector could be liable for breaking open the machine where there are reasonable grounds.

To put some reality into this situation, I would hope that come January 1 or February 1, there's no reason for an inspector to break into any machines, that these machines are gone. I would hope, six months after the first of the new year, that there are no machines around so in essence this whole section becomes redundant.

In practice, an inspector would go in, ask an operator to open the machine, and that would be the end of it. The tobacco would be removed.

1140

**Mr Jim Wilson:** Mr Chairman, in terms of the new subsections 13(8.1) and (8.2), if people refer to section 16 and the government's amendment thereto, currently in section 16 there is the ability of the inspector to seize the entire vending machine, but also the onus to return it within a reasonable period of time. You have to look at what the government's also proposing in an amendment to subsections 16(2) and (3), where there's a reasonable grounds test. I think a reasonable grounds test also must be contained in this amendment, and I understand that's the drafting that's going on now.

Also, in the case where the machine is damaged, I don't see why we can't have a financial liability on the crown. I ask legal counsel, if the inspector is found not to have had reasonable grounds, what penalty is imposed? Does the court just say, "I guess an apology is good enough for wrecking that machine"?

**Mrs Haslam:** That's my question; the same rights I would have under my trunk being broken.

**Mr Jim Wilson:** As the crown gets the proceeds of any contents of this machine, the crown should also be responsible for any liability of damage to a machine when an error is made. That's common sense.

**Mrs Haslam:** Yes, but there wouldn't be any proceeds if there wasn't any—

**Mr Jim Wilson:** No, but in other cases where it's a legitimate seizure or forfeiture, the proceeds go to the crown; therefore, it would seem reasonable that the crown should also pay for any errors that might be made.

You're probably right. A reasonable approach to this is that the likelihood of this happening is small, but obviously there is a likelihood of it happening or it wouldn't even be in this act. Somebody's thought that this might happen and that we have to put these provisions in the act in two different sections. So what's the answer if the inspector is found in error, didn't have reasonable grounds—

**Mrs Haslam:** Or did have reasonable grounds.

**Mr Jim Wilson:** —under either of these sections? What's the penalty?

**Mr Williams:** The answer is the same as I gave to Ms Haslam. If we amend the section the way it's being rewritten by legislative counsel, I don't think you have to say so in the legislation, but certainly there could be liability if somebody was found to have broken into a machine without reasonable grounds. I think that applies to any statute where an inspector or a police officer exceeds their powers under the law in the particular circumstance.

**Mr Jim Wilson:** So no need to specify and the courts would then have flexibility to decide?

**Mr Williams:** Yes, that would be correct.

**The Vice-Chair:** Any other speakers to Mr Sterling's amendment to subsection 13(8.1)? It's adding at the end of that subsection the words "if tobacco is found therein." All in favour of Mr Sterling's amendment? Opposed? The amendment is lost.

Mr O'Connor's motion to amend subsections 13(8.1) and (8.2): Ms Carter was listed to speak to it previously. Do you wish to speak at this time?

**Ms Jenny Carter (Peterborough):** I don't buy a lot of things out of vending machines, but can't you always tell whether there's any of the product there? If not, you're inviting the public to put money in and lose it. It seems kind of basic but—

**The Vice-Chair:** Mr O'Connor, do you wish to respond to that?

**Mr O'Connor:** Mr Chair, at this point I would like to withdraw the two motions I put and re-move the amendment—I'll read it slowly—that hopefully captures the intent as committee members' concerns have been raised.

**The Vice-Chair:** Mr O'Connor now withdraws the motion before the committee and presents a replacement motion. Proceed.

**Mr O'Connor:** I move that section 13 of the bill be amended by adding the following subsections:

"Same, vending machines

"(8.1) An inspector conducting an inspection may open a vending machine for the selling or dispensing of tobacco if,

"(a) the vending machine is operable and is in a place to which the public has access;

"(b) the owner or operator of a place referred to in subsection 7(1) refuses or is unable to open the machine; and

"(c) the inspector has reasonable grounds to believe that there is tobacco in the machine.

"Exemption from liability

"(8.2) No person is liable for damage done to the machine in connection with the opening;

"Seizure and forfeiture

"(8.3) The inspector may seize any tobacco and money found in the machine; the tobacco is forfeited and shall be dealt with as the Minister of Health directs, and the money is forfeited to the Minister of Finance."

I hope that addresses the concerns raised by my colleagues.

**The Vice-Chair:** Could we have copies produced and circulated to the members?

**Mrs Haslam:** I want to know why (a) says "and"; that it's not two separate sections. You're saying is if it is operable and in a place accessible. I'm wondering why it shouldn't be (a) if it is operable, and (b) if it is in a place accessible.

**Mr O'Connor:** Yes, I'll change the "and" to "or" and have it circulated as such so we can see that. The "and" would be struck out and we'll put in the word "or."

**Mrs O'Neill:** In terms of the "refuses or is unable to open," what is the "unable to open"? Lost the key? Intoxicated? What have you got in mind? Why not "refuses"?

**Mrs Haslam:** If they don't have keys and they use that as an excuse—

**Mrs O'Neill:** There must be a legal reason.

**Mr O'Connor:** The person we're going to ask to open the machine may not have the key. The owner of the premises on which the machine's found doesn't have the key because that person may not be the person who actually stocks the machine, puts the tobacco products into the machine. We're trying to anticipate some things but at the same time respect the intent Mr McGuinty's raised.

**Mrs O'Neill:** It just seems to me that the owner is at quite a disadvantage as most of the owners of these vending machines are not present. Then who is liable: the owner of the premises or the owner of the vending machine? This gets very complicated, and I think we have to be quite clear where the onus is going to lie.

**Mr Jim Wilson:** I'm ready to vote on the amendment without having the version in front of me. I took notes as the parliamentary assistant read the amendment. The new drafting meets the concerns I had.

**The Vice-Chair:** I had Ms Caplan listed to speak to Mr O'Connor's motion. However, the motion has been replaced with another motion. Did you wish to comment?

**Mrs Caplan:** No. I'm supportive of the change that's been made. It addresses my concerns.

**The Vice-Chair:** Mr Wilson, it's being circulated now, somewhat quicker than we expected. Thank you. Mr O'Connor has moved the motion that's now before you. Any further discussion?

1150

**Mr McGuinty:** Just so I'm clear on this, if an inspector wants to open the machine, there are certain prerequisites that have to be met. Requirement number one is that the vending machine has to be operable or that it's in a place to which the public has access; requirement two is that the owner or operator of the place referred to refuses or is unable to open the machine; and requirement three is that the inspector has reasonable grounds. Is that correct?

**Mr O'Connor:** Yes.

**Mr McGuinty:** All three there have to be met.

**Mrs Caplan:** And he must believe it's for tobacco



use, so that it's not inadvertently a candy machine.

**Mr O'Connor:** We should have no broken bubble gum machines as a result of this.

**Mr McGuinty:** The "exemption from liability" in (8.2) says, "No person is liable for damage done to the machine in connection with the opening." That's a little open-ended. I'm wondering if it should be saying "in connection with the opening so long as the machine was opened in accordance with the foregoing" or something to that effect.

**Ms Sibylle Filion:** Could you repeat the suggested wording?

**Mr McGuinty:** Subsection (8.2) presently reads, "No person is liable for damage done to the machine in connection with the opening." I want to ensure that the opening that's referred to in (8.2) was the kind of opening that's authorized pursuant to (8.1).

**Ms Filion:** We could add it in and it wouldn't harm it, but I don't think it is necessary in this instance that the two follow directly. The cross-referencing, in my opinion, isn't necessary.

**Mr McGuinty:** Would you stake your career on it?

**Ms Filion:** I would hope the member wouldn't put me in that position.

**Mr Jim Wilson:** You don't have to answer that. Politicians never answer those questions.

**Mr McGuinty:** It's just a concern I see on the face of it.

**Ms Filion:** Consistent with the trend towards plain language, there's a trend in reducing the number of cross-references in drafting.

**Mr McGuinty:** And this is the only section that's talking about "opening" anyway, right?

**Ms Filion:** That's right.

**Mr O'Connor:** Good. We don't want to put too many lawyers out of work.

**The Vice-Chair:** Anyone else? Now that you've heard Mr O'Connor's motion to amend section 13, all in favour of the motion? Opposed? Carried.

**Mr O'Connor:** I have a further motion. I move that section 13 of the bill be amended by striking out subsection (9).

As you know, we circulated this and discussed many elements of this with the Ministry of the Attorney General. It was suggested that this wasn't necessary to be in here.

**Mr McGuinty:** Are you making reference to—I can't seem to find a copy of it—this provision about the rights of the person being questioned?

**Mr O'Connor:** This also refers to some of the concerns raised by Mr Wilson during the hearings.

**Mr Jim Wilson:** My concern was not to delete the clause but more about whether there was an onus on the inspector to ensure that people were aware of their rights. This makes them less aware. At least when it was in there they had something to refer to.

If it's the government's position that everyone assumes they have a right to legal counsel when being questioned

by an inspector, I can tell you most people wouldn't know that. If the Attorney General is saying, "You don't need that because people can get legal counsel if they want"—I'd prefer that you not remove it. In fact, my argument was that they should be informed of their right to have a lawyer present during questioning.

Don't forget, you're going to be dealing with big, big dollars, big, big business. If there's a need for a raid and inspection and all that's contemplated under these sections—in my opinion, people aren't going to get into illegal matters in this area unless it's big business, certainly, Mr Chairman, in your area of the province, where you're well aware of the smuggling and the big business that was going on. The right to legal counsel is something people should be informed about.

**Mr O'Connor:** I may have to call for some legal counsel on this, but what we're talking about is legal counsel before a charge has even been laid. I think we're really getting into a conundrum once we start saying you have the right to legal counsel before a person's been charged. I don't know what we'd be doing if we started putting that in other pieces of legislation. It's an awkward thing.

**Mr Jim Wilson:** We have parallels—not legal counsel, but we've got an Advocacy Act that entitles you to all kinds of counsel. What can't the poor person who's being questioned by an inspector know of his or her right to legal counsel? Under the Advocacy Act, we have to read forms to children, for goodness' sake. It just seems to me it's a fundamental right. If it's a right in society, people should be aware of their rights.

**Mrs Haslam:** Are butchers informed of their rights when an inspector goes in? Legal counsel?

**Mr Sterling:** Here we are back to the meat question.

**Mrs Haslam:** Yes, back to the meat question. Let's get to the meat of this question.

**Mr Williams:** Maybe I can clarify. Our advice from the Attorney General's office was that in light of subsection 13(11) and especially subsection 13(14), there could be a conflict between those two sections and subsection (9). Subsection (14) says, "No person shall hinder, obstruct or interfere with an inspector." I don't think we want to leave an inspector in an awkward position where they come in to do an inspection and the person whose premises are being inspected on a Wednesday says: "Sorry, my legal counsel's in Ottawa. They won't be back till Monday." Then the inspector is completely hamstrung in carrying out an inspection. Our advice is that the two sections conflict, that it should be removed.

In any event, as the parliamentary assistant has pointed out, certainly if somebody's charged, they have the right to legal counsel once the charge has been laid.

**Mr Sterling:** In other words, what I'm getting from legal counsel is that taking it out is not only a matter of saying it's redundant, but that you're taking it out so you don't want these people informed of their rights. Is that right?

**Mr O'Connor:** The point is that we're going into an area where, before a person's been charged with something the inspector may find them in violation of, they've

got the right to have legal counsel there for whatever type of inspection. It goes beyond what we've got now. I think it's pretty reasonable, the way it's written, to have that withdrawn, because having legal counsel there before someone's even been charged doesn't seem to make much sense, unless you're a lawyer.

**Mr Sterling:** The advantage of putting it in here is that this act won't be read by the person who's actually involved in this altercation. It will be read by the inspector who is charging or questioning this particular individual. For the sake of instruction of that inspector, it may be useful to have it left in the act. That's the way I look at it: the inspector being better informed of what the rights of the citizen are when he's questioning this particular individual.

**Mrs Haslam:** Does the butcher have a lawyer with him when the health inspector inspects his shop?

**Mr Sterling:** He's entitled to.

**Mrs Haslam:** Then he knows he's entitled, just like this particular—

**Mr Jim Wilson:** I doubt he knows.

**Mrs Haslam:** Yes, he's entitled to it, under the Human Rights Code, under the charter.

**Mr Williams:** Under the charter, if you want to have counsel present, you can have counsel present. You don't need to say so under the legislation.

**Mrs Haslam:** It's there. We don't have to put it in this legislation, because it's already out there under the charter.

**Mr O'Connor:** The key here is that when somebody's been charged, of course they've got a right to counsel.

**Mr Jim Wilson:** That may be true, that at all times people are entitled to legal counsel—and thank goodness they're here during committee hearings—but given that you're bringing in a new act with new powers for inspectors, when this particular subsection 13(9) appeared, the concern was that it wouldn't really be a level playing field, because you're asking for the business records and a number of business-related things from the person who's subject to the questioning. Perhaps we could call it a courtesy, if it's not necessarily legally required, that the inspector be able to say, "By the way, before we go any further, you are entitled to legal counsel." Maybe you can put a section in that ensures that somebody has a reasonable time to obtain counsel, not to delay the thing till Monday, as you said, if the inspection was on Wednesday.

**Mrs Haslam:** Why don't we send them a letter saying: "We're going to inspect your store for illegal cigarettes on Friday. Could you have your lawyer available?"

**Mr Jim Wilson:** No, the point is you would be there and you would have reasonable grounds, I would assume, because the test is in here, for all the things you're going to ask for. If you want to go through my filing cabinets, I'd like to be informed whether I have the right to legal counsel. I don't think people know that under the charter right now.

Anyway, those are the thoughts I have on it. I suspect we're not getting very far.

**The Vice-Chair:** Did you wish to speak, Ms Haslam?

**Mrs Haslam:** Let's just vote on this.

**The Vice-Chair:** You've heard Mr O'Connor's amendment. All in favour of Mr O'Connor's motion, please indicate. Opposed? Amendment carried.

Section 13, as amended: All in favour? Opposed? Carried.

The committee will adjourn until 2 pm.

*The committee recessed from 1202 to 1415.*

**The Vice-Chair:** Good afternoon, ladies and gentlemen, the social development committee is continuing clause-by-clause consideration of Bill 119. We're down to section 14 and there is a government motion.

**Mr O'Connor:** I move that section 14 of the bill be struck out and the following substituted:

"Offences

"14(1) A person who contravenes subsection 3(1), 3(2), 3(6) or 4(1), section 5 or 9 or subsection 13(14), 15(4), 16(6), 17(2.2) or 17(3) is guilty of an offence and on conviction is liable to a fine determined in accordance with subsection (3).

"Continuing offence, signs, smoking areas

"(2) A person who contravenes section 6 or 10 or subsection 10.1(2) or 17(1) is guilty of an offence and on conviction is liable, for each day or part of a day on which the offence occurs or continues, to a fine determined in accordance with subsection (3).

"Determining maximum fine

"(3) The fine, or daily fine, as the case may be, shall not exceed an amount determined as follows:

"1. Establish the number of times the defendant has been convicted of the same offence during the five years preceding the current conviction.

"2. If the defendant is an individual, the amount is set out in column 3 of the table to this section, opposite the number of previous convictions in column 2 and the section or subsection number of the provision contravened in column 1.

"3. If the defendant is a corporation, the amount is set out in column 4 of the table to this section, opposite the number of previous convictions in column 2 and the section or subsection number of the provision contravened in column 1.

"Sequence of convictions

"(4) In establishing the number of times the defendant has been convicted of the same offence for the purposes of subsection (3), the only question to be considered is the sequence of convictions, and no consideration shall be given to the sequence of commission of offences or to whether an offence occurred before or after a conviction.

"Continuing offence, vending machine

"(5) A person who contravenes subsection 7(1) is guilty of an offence and on conviction is liable, for each day or part of a day on which the offence occurs or continues, to a fine of not more than \$2,000.



"Offence, failure to submit report

"(6) A person who contravenes section 8 or a regulation made under clause 18(1)(f) is guilty of an offence and on conviction is liable to a fine of not more than \$100,000.

"Duty of directors and officers

"(7) A director or officer of a corporation that engages in the manufacture, sale or distribution of tobacco has a duty to take all reasonable care to prevent the corporation from contravening this act.

"Same

"(8) A director or officer of a corporation that owns, occupies, operates or maintains a place referred to in paragraph 1, 5, 9.1 or 13 of subsection 9(1) has a duty to take all reasonable care to prevent the corporation from contravening subsection 10.1(2).

"Offence

"(9) A person who has the duty imposed by subsection (7) or (8) and fails to carry it out is guilty of an offence and on conviction is liable to a fine of not more than \$100,000.

"Same

"(10) A person may be prosecuted and convicted under subsection (9) even if the corporation has not been prosecuted or convicted."

I've got a table here to read, and what I'll do is go down through the table column by column.

"1. Provision contravened: 3(1), 3(2), 3(6), 4(1), 6, 10, 10.1(2), 13(14), 15(4), 16(6), 17(1), 17(2.2), 17(3); 5; 9.

"2. Number of earlier convictions: 0, 1, 2, 3 or more; 0, 1, 2, 3 or more; 0, 1 or more.

"3. Maximum fine—individual: \$2,000, \$5,000, \$10,000, \$50,000; \$2,000, \$5,000, \$10,000, \$50,000; \$1,000, \$5,000.

"4. Maximum fine—corporation: \$5,000, \$10,000, \$25,000, \$75,000; \$100,000, \$300,000, \$300,000, \$300,000."

That certainly was a mouthful, Mr Chair, and I appreciate the committee's indulgence as I read that.

**The Vice-Chair:** I believe the only change from what's been circulated is the addition of 9.1 under "Same," subsection (8).

**Mr O'Connor:** That's correct.

**The Vice-Chair:** Discussion?

**Mr McGuinty:** In the new section 14, in subsection (8), we're talking about directors and officers "of a corporation that owns, occupies, operates or maintains a place referred to in paragraph 1, 5 or 13"—

**Mr O'Connor:** It includes 9.1, the amendment by Mr Sterling. That wasn't in what was circulated, but I read it and added it.

**Mr McGuinty:** Yes. In other words, we're saying we can go after the people who run the companies if they're breaching—correct me if I'm wrong here—the law in so far as allowing people to smoke in a non-designated place is concerned.

**Mr O'Connor:** It also includes the areas of sale as

well. The table will be referred back to, the fines in the table.

**Mr McGuinty:** Right, but does it say we can go after directors and officers if they've—sorry.

**Mr O'Connor:** Given that this is a rather technical one, maybe what we could do is ask our legal counsel who we've got here at our disposal to clarify where you're having some difficulty, Mr McGuinty.

**Mr McGuinty:** It seems to me, Frank, that we've got a distinction here and I just want to first of all confirm that I'm right in this regard. It says that if you are caught selling tobacco—well, no. If you commit any offence under the bill and you're a corporation, you can't go behind the corporate veil to get after the people who run the show. You can't get at the directors and officers except, and there seems to be one exception here, you can get at the directors and officers if they allow smoking to occur in a non-designated area or in an area that doesn't meet the prescribed criteria. Am I right?

**Mr Williams:** I guess there are two things. Obviously, subsection (7), which is very similar, is to catch the sort of situation where you've got illegal selling that could possibly take place. Subsection (8), which is the one you're asking about, and the contravention of 10.1, is the situation that has arisen because of the motion that was moved this morning, whereby if there are places where smoking is to be permitted, the onus is put on the owner or occupier to ensure that the signs that are there are the proper signs and to prevent people from signing an area as being a smoking area when in fact it's not really a smoking area. The onus is on the owner or occupier. In the case where that's a corporation, it's just to ensure that the officers or directors of the corporation have to take some responsibility for what the corporation does. That's all it's intended to do.

**Mr McGuinty:** Are we saying that volunteer directors who sit on boards of hospitals, psychiatric facilities, colleges, universities, could be liable for a \$100,000 fine here?

**Mr Williams:** I guess in theory that if they approved the signing of a part of the campus where they knew full well there was to be no smoking, probably the answer is yes, but certainly an officer or director who was diligently carrying out his duty would not so approve such a thing. If they voted against it when there's a meeting of the board of directors, then I would assume there would be no liability, as long as they exercise their duty in a proper fashion. That applies to anything that an officer or a director of a corporation does in any other regard, not just smoking and tobacco-related offences.

**Mr McGuinty:** I'm particularly concerned, though, about volunteer directors. It's been my sense, as the law through various statutes has evolved, that we're making it harder and harder to get people out there to volunteer to do the kind of work that needs to be done to keep things moving in this province. My concern is that we're now going to set up another roadblock in the way of volunteer directors.

Volunteer directors by and large are not necessarily up to snuff on the legal ramifications of the decisions they

make. They show up at a meeting. There's an agenda placed before them. They're there oftentimes because they have some connection with an institution or some presence in the community and they're there out of a spirit of goodwill. They're told to do things and by and large they approve them. Some of them have more time and they question, they get into them.

That's my concern, Mr Parliamentary Assistant. What we're doing here is saying to volunteers who happen to be directors, who aren't being paid any money, "You now could be fined \$100,000 for not staying at home and watching TV at night but rather coming out to the meeting and trying to get involved in the community."

**Mr O'Connor:** I don't think this is much different than other legislation requirements placed on boards of directors. For example, it could be workplace health and safety types of areas. I would ask legal counsel to comment on that.

**Mr Williams:** Just one further point: I'm not an expert on corporate law and all the ramifications, but it's my understanding that most corporations, and I would assume non-profit corporations where they have volunteer directors in a lot of instances, do have liability insurance that covers the normal types of things, where a director in all good faith carries out a duty, and as a result of some decision that's made by the board, something happens and he's sued.

My view would be that if they're doing something in good faith and they honestly believe and have been given information upon which they've acted, and they've acted in good faith and taken reasonable steps to ensure that what they're doing is proper, there would be no liability. If they're clearly doing something outside their authority, then I can't see where the problem would lie.

1430

**Mr McGuinty:** The concern being again that they don't know when they're doing something outside their authority, and sometimes they don't receive the advice that a professional director would demand to receive before they move forward.

Just to bring forward another example, student centres in our college and university campuses are governed by a corporation which is run by students, so in student centres the directors and officers are all students. If a mistake occurred, if an improper decision was made with respect to abiding by prescribed criteria as to where smoking would be allowed within the student centre—that's where all the pubs and the restaurants are, and sometimes there's music listening and there are reading rooms and things that the students have set up for themselves—what we're saying is for the students to be subject to a \$100,000 fine.

It just seems to me to be pretty far-reaching and—I hate to use the word because it's overused—draconian in terms of how far we want to go here to deal with directors. I'm specifically concerned with volunteer directors, not professionals.

**Mr O'Connor:** I appreciate your concern. The amendments that I've made in this section aren't much different than some technical changes to reflect other

changes that have been made. The intent of this section remains pretty much intact. In fact, this is what we went out on the road with for public hearings. I don't recall a lot of conversation about this as we were on the road. I hear your concern, though.

**Mr Williams:** One other comment that I might make is that the amounts that are set out in the table are maximums. It doesn't mean that the court is necessarily going to impose a \$100,000 fine on a director of a student council. That's only the maximum amount. As you see, there's no minimum amount. So I'm sure the court, and the court usually does in these sorts of circumstances, would take into consideration the type of situation, the type of director that you have, if it's a volunteer director, and the information that the director had at his or her disposal when the decision was made, and the fine or lack of fine would reflect that.

In fact, the courts traditionally tend to be very reluctant, in those types of situations, to impose large fines. That's why we didn't put a minimum in, because we didn't want the court to be placed in the awkward position of trying to decide whether to convict or not convict and maybe not convict because there was such a high minimum fine that in essence the act would never work.

**Mr McGuinty:** I've registered my concerns. I think we've had some good discussion here in terms of the intention of the government on this matter, which could form a useful basis in the event that somebody was ever charged under this. I'm going to vote in favour of section 14, as amended. I think it's very important, obviously, that we have penalties and maximum fines in order to ensure that we give this bill some teeth.

**The Vice-Chair:** Does any other member wish to speak or comment?

**Mr Jim Wilson:** It's really a point of order, Mr Chairman, that you may want to rule on. We certainly want to get this bill done this afternoon, but I just wonder if we can vote on this particular section, given that the table contains sections we've not yet dealt with and that are subject to amendment. Not only the table, but this section deals with other sections in terms of fines. My recommendation would be to stand it down till we deal with sections 15, 16 and 17. For example, the table presupposes the passage of an additional subsection to the bill, 17(2.2). We've not dealt with subsection 17(2.2).

**The Vice-Chair:** That's correct. I think we should go on. We'll stand this down and go on with the other sections.

If it's agreed, we'll then stand Mr O'Connor's motion down at this time and proceed to section 15. There is a government motion regarding section 15.

**Mr O'Connor:** I move that section 15 of the bill be struck out and the following substituted:

"AUTOMATIC PROHIBITION

"Tobacco sales offences

"15(1) For the purpose of this section, the following are tobacco sales offences:

"1. Contravening subsection 3(1) or 3(2), section 5, 6 or 7, or subsection (4) of this section.



"2. Contravening section 8 or 29 of the Tobacco Tax Act.

"Notice

"(2) On becoming aware that the following conditions have been satisfied, the Minister of Health shall send a notice of the prohibition imposed by subsection (4) to the person and to all wholesalers and distributors of tobacco in Ontario:

"1. The person has been convicted of a tobacco sales offence committed in a place owned or occupied by the person.

"2. The person was convicted of another tobacco sales offence committed in the same place during the five years preceding the conviction referred to in paragraph 1.

"3. The period allowed for appealing the conviction referred to in paragraph 1 has expired without an appeal being filed, or any appeal has been finally disposed of.

"Date

"(3) The notice shall specify the date on which it is to take effect.

"Sales, storage and deliveries prohibited

"(4) During the applicable period,

"(a) no person shall sell or store tobacco in the place where the tobacco sales offences were committed; and

"(b) no wholesaler or distributor shall deliver tobacco to the place or have it delivered there.

"Applicable period

"(5) For the purposes of subsection (4), the applicable period is,

"(a) the six months that follow the date specified in the notice referred to in subsection (2), if the person has been convicted of one other tobacco sales offence committed in the same place during the five years preceding the current conviction;

"(b) the nine months that follow the date specified in the notice, if the person has been convicted of two other tobacco sales offences committed in the same place during the five-year period; and

"(c) the twelve months that follow the date specified in the notice, if the person has been convicted of more than two other tobacco sales offences committed in the same place during the five-year period.

"Defence

"(6) It is a defence to a charge under subsection (4) that the defendant had not received the notice at the time the offence was committed.

"Exception

"(7) The prohibition on storing tobacco does not apply to small amounts of tobacco for the immediate personal use of persons who work in the place.

"Sequence of convictions

"(8) In establishing the number of times a person was convicted of another tobacco sales offence for the purposes of this section, the only question to be considered is the sequence of convictions, and no consideration shall be given to the sequence of commission of offences or to whether an offence occurred before or after

a conviction."

This reflects some of what we heard through the hearings and also brings into play a conviction that would be under the Tobacco Tax Act.

**1440**

**Mrs Haslam:** It's the teacher in me that wants a clarification of some of the language. On the second page of the motion under "Sales," (4), it talks about "place" and in "Applicable period," (5), it talks about "place." In (4), what happens if that place is bought out by another person? And in (5), what happens if the person charged with an offence changes his location? Because it says "place." It says "if the person has been convicted...in the same place during the five years preceding the current conviction."

**Mr O'Connor:** It would apply to the place.

**Mrs Haslam:** So if I opened a store front, sold tobacco, was charged, closed the store front, opened another store front and was charged, you couldn't do a thing to be me because it's a different place.

**Interjection:** That is correct.

**Mrs Haslam:** Yea, bingo. Isn't that interesting. Could I have some clarification on that? As Ms Caplan often says, this is legislation and we have to be very careful in what we put in place.

**Mr Williams:** That's correct. When we were trying to draft this, we found we had to make a decision on the balance of how we could enforce this. Part of the problem too is the fact that because this is an automatic statutory prohibition, you've got to be able to link where the offence has taken place, where you send the notice, and it got very difficult if we were trying to just track the person.

We also ran into a problem where, if the person is a corporation, does that mean you can't sell tobacco, say, to Shoppers Drug Mart if it's been committed in one store? It means that you can't sell any tobacco to Shoppers Drug Mart and they can't use tobacco in any of their stores. So we wanted to relate the conviction to the place where the offence took place.

In addition, there is also the problem of signing the premises where there have been two or more convictions. We wanted to make sure that we have the ability to go in and put a sign on the place where the convictions had taken place. We're not saying it's perfect, but this was the best scheme we could come up with that we felt would work with the automatic statutory prohibition scheme.

**Mrs Haslam:** So the owner is ostensibly responsible for his staff and he gets charged and his store doesn't sell tobacco?

**Mr Williams:** That's correct.

**Mrs Haslam:** It's not linked at all to the people.

**Mr Jim Wilson:** Ms Haslam raises an excellent point that I certainly didn't catch in my reading of it. I guess what you're saying, though, is that if a corner store—it seems bizarre to me that a place could be convicted. I know it's the owner or occupier who is actually convicted, but if a charge exists on the place or pertaining to

the place and you sell that place to someone else and subsequently there's a conviction to the previous owner, I guess, would the place still have to have a sign put up even though it's under new ownership?

**Mr Williams:** I would say the answer is yes. It gets very complicated. The logical consequence of what I think you might want to ask when we're finished with this is that this seems unfair. The type of situation that we also want to prevent is where one family member owns the business, and in order to get around the type of situation where you might have a section saying it doesn't apply where the business is sold, we don't want to raise the situation where the family member could sell it to somebody else and the business carries on and they still sell tobacco. As I say, I'm not saying it's a perfect scheme, but it's the best scheme we could get to work the way we wanted to set it up, with the automatic statutory prohibition, without getting into some other complicated scheme.

**Mr Jim Wilson:** Concerning your comment about Shoppers Drug Mart, their stores are numbered and, secondly, they can be identified by address, so I don't see a problem there.

**Mr Williams:** But I'm talking about the average mom-and-pop store. There are hundreds and thousands—

**Mr Jim Wilson:** In your previous explanation of why you had to take this model, you used Shoppers Drug Mart and you didn't want to stop selling cigarettes to all Shoppers Drug Marts. First of all, they won't be allowed to sell cigarettes, so they are out of the picture, and secondly, they can be identified by street address.

**Mr Williams:** Just to clarify what I said earlier, you could get the sort of rather strange situation where—I don't want to zero in on Shoppers Drug Mart—a large chain, if the chain was convicted once and you didn't relate it to the place, then in essence it couldn't sell tobacco in any of its stores. They've got 100 stores and after the second conviction, you relate it to the person. It means that none of their stores would be able to sell tobacco. Likewise, the wholesalers and distributors would be prohibited from selling tobacco to that chain. I don't think we want to prevent that.

**Mrs Haslam:** No, I understand; it's the lesser of the two.

**Mr Jim Wilson:** Could you not make an exception for corporations?

**Mrs Haslam:** Or is there something you could add—

**Mr Jim Wilson:** Because what you're doing is penalizing the mom and pop shops, really.

**Mrs Haslam:** No.

**Mr Jim Wilson:** Because this charge could take a long time to be disposed of or a conviction rendered, and things happen. People don't wait around. Here's a question: If I were to buy a store from someone where there's a charge, would I be notified as part of my real estate dealing that there's a charge pending? Because that could really affect my business, these signs that have to be put up afterwards.

**Mr Williams:** Certainly, if you're a diligent purchaser, you would go and inspect the premises and see

that there's a sign in the premises saying that they can't sell tobacco.

**Mr Jim Wilson:** No, but that's only upon conviction. What about pending? What about if I'm charged—I own the store—and I say: "Forget it, I only sell cigarettes and a few other things anyway. I'm just going to close this store. I'll sell this store"? There's a charge pending. There's no sign up yet. Somebody naively buys it and then two months later I'm convicted of the offence and that old store that I sold has to put the sign up, which is the reason I got out of it—

**Mrs Haslam:** And if you were convicted of the offence, you could still go and open one next door.

**Mr Jim Wilson:** Yes. That's another great point.

**Mr Williams:** Maybe to clarify some of the confusion, although the charge relates to the premises where the offence has taken place, it's still the person who owns the premises who's being charged. They're the one who commits the offence more than once in that location.

**Mr Jim Wilson:** But when it comes to signage, the premises retains the sign after the conviction, regardless of who owns it now.

**Mrs Haslam:** And would a second conviction in a second location count as a second conviction or only a first?

**Mr Williams:** I'm sorry?

**Mrs Haslam:** I've sold it to good old Mr Wilson here and he can't sell tobacco in his store, while I on the other hand can open a store next to him and I can sell tobacco. You catch me selling to a minor and it's my second conviction, but only my first in that place.

**Mr Williams:** I would concede that your example is a possible scenario, but I think you'll find that certainly mom and pop stores, people who own variety stores, don't just easily pick up and move next door every day. They just can't do that physically. Most businesses just aren't run that way. My argument would be that that's not a terribly likely scenario to take place.

**Mr Jim Wilson:** I'm not thinking of a large store.

**Mrs Haslam:** We're just trying to find ways to be sure.

**Mr Jim Wilson:** What about a tobacco kiosk? It moves to the next mall because this one—I mean, a tobacco kiosk with one of these signs, I would assume the effect of this thing is not only to discourage young people but to discourage customers. If I had one of these signs pending or whatever else comes with the conviction, why wouldn't you just try and get out of your lease and move? Because that's all you sell, that and chips and pop and candy bars, I guess. That's what's likely to occur. I agree that mom and pop stores that have been in the neighbourhood 20 years aren't like to go too far.

**Mr Williams:** I think the thing we've got to be cognizant of is the two things we're trying to prevent. One is you're trying to give a message to the public that selling to minors is a no-no. The other thing you're trying to do is prevent the vendor from selling to the minor in the first instance. That's the whole gist of this. It's not a matter of putting people out of business or getting them



to move their businesses. I think we're looking at this in a rather skewed manner.

**Mr Jim Wilson:** I don't think we are, because you're taking about something that somebody else did wrong and you're making the new owner inherit that problem. The place didn't sell the cigarettes; a person sold the cigarettes.

**Mrs Haslam:** If you have looked at that scenario, the one that I'm raising, if this is your best effort and this is the best way to deal with it, that's fine. I'm only looking at other options and whether other options were investigated in this particular issue.

**Mr Williams:** Yes, they were. I guess what I'm saying, and I said that earlier, is that it's not perfect. We could have done it in other ways, but we found that the other ways where we tracked the person, rather than the location where the person happened to operate, got us into worse conundrums and more trying to manoeuvre with our words. When all was said and done, this shook down as being the method that worked the best, and we worked this out. We had long consultations with the Ministry of the Attorney General on enforcement and how we could enforce this and best come up with an automatic statutory prohibition scheme, and this was the method that seemed to be the best when all was taken into consideration.

1450

**Mr McGuinty:** This is a problem. Is there a registry? Does the bill create a registry so that if I was a buyer now, in addition to the gas, the hydro and the water, property taxes and business taxes, and employee severances that I have to look out for and make sure those are covered, now I've got to check something else? Is there something else I can check to determine if there's been a conviction?

**Mr Williams:** I'm not up on how freedom of information relates to how available information is on convictions or when people have been convicted, so I'm not sure I can really answer this properly. But if there was no impediment under freedom of information, I don't see why—certainly when the ministry is going to be tracking convictions, they're going to keep very close track of who's been convicted where. Otherwise, obviously, the scheme isn't going to work. Assuming that there are no impediments, and I'd have to check into whether there are impediments, I don't see why the ministry couldn't set up some way of somebody finding that out.

**Mr McGuinty:** Yes, because you made reference to a buyer being diligent. I recognize that's an obligation on a buyer, but there has to be some avenue for him or her to exercise that, within which they can exercise that diligence.

**Mr O'Connor:** Mr McGuinty, in this instance what we're dealing with is the automatic prohibition, so this is after the convictions have been levied. If the person was at a point before the automatic prohibition was to come into play—say they only had the one conviction and there was a new owner—then my understanding is that it would apply to the previous owner. The new owner then would come into it without a conviction.

What this deals with is the automatic prohibition, which is that they've been found in contravention, the signage would go up, the notices would go out and the people supplying the tobacco to the premises—all the notices would go out. It's at the point where the convictions have all taken place and this person is no longer able to sell. So when a person wants to go into the store to take a look at premises that they were about to purchase, there would be signs already in place. That's what this portion is, to put the signs in place and to have the products removed.

**Mr McGuinty:** So if I contravene the legislation on day one, and on day two I sell the premises, does that mean the premises will be subject to a prohibition if I'm convicted on day three?

**Mr O'Connor:** That wouldn't take place on the first conviction.

**Mr McGuinty:** Well, if it was whatever, you know; if it was my third conviction.

**Mr O'Connor:** There would be a process with that as well. Before the prohibition comes into place, there's the opportunity for the person to appeal and what not. It doesn't happen overnight. There is a process and you'll note that when I was reading this, I talked about some of the criteria that had to be met before the automatic prohibition actually came into place.

**Mr McGuinty:** I don't think that changed anything. I think the problem is that the penalty is visited upon the premises—

**Mr O'Connor:** Yes, that's the way it is. You're right.

**Mr McGuinty:** —rather than the guilty person.

**Mr O'Connor:** The difficulty is that the guilty person may be a person who owns many stores, but the one premises that has been found could be managed by—they could have six managers or whatever working for them. It's those premises that, yes, then would be subject to this section of the bill.

It was a difficult situation to try to come up with the best-case scenario, where this shop owner could have half a dozen shops but only one premise has been a problem, not upholding the legislation and following the rules. All the rest of the stores, it was felt, shouldn't be subject to the same rules because they had one bad manager out of the lot. The owner, I would assume, would have approached that manager or whatever. The best way to deal with it, it was felt, in a fair manner, would be to do it to the premises, put the automatic prohibition in for the premises. It was a difficult situation.

**Mr McGuinty:** If I run a business at 18 Bank Street, my premises become subject to a prohibition. If I shut down and set up at 20 Bank Street, I'm in the clear?

**Mr O'Connor:** Yes, you would be, given that the premises themselves—I would think, though, that a shop owner isn't about to put himself in a situation where they're found in contravention and go through a process of moving and the expense just to get beyond what they've been convicted of. There were some areas here where choices had to be made, and somewhere in there we had to find what was the most reasonable way to get to the end that we wanted, which was premises or a shop

that's been found in contravention where the prohibition needs to come into place—could be met.

**Mr McGuinty:** I'm just thinking aloud here, because this problem has just been raised now. I look at clause 15(4)(a) here on page 2 of the amendments, "No person shall sell or store tobacco in the place where the tobacco sales offences were committed;" or in any replacement premises owned or operated by a person who was convicted.

**Mr Williams:** If I can follow up on something the parliamentary assistant has already said, to maybe put everybody's mind a little bit more at rest as to how this is actually going to work, the notice that goes out from the minister saying that you now have a statutory prohibition against selling tobacco doesn't take place until all the time periods have expired for both appeal and the notices of appeal. In essence, all the appeal periods have expired, and when the sign goes up, it goes up when you're still there in the store. It's not like you're going to have to wait to see if it's appealed; the sign doesn't go up until after the appeal period expires. In essence, if you sold the store before the second conviction, it's not going to kick in, in any event.

The other thing I think worth mentioning is that if somebody moves to another location and is convicted of a tobacco sales offence, the fine is a progressive fine as far as your personal convictions are concerned. It may be \$50,000 the first time, if you're a corporation; \$100,000 the next time. That still stays in place.

**Mrs Haslam:** I'm almost afraid to ask. In (a), if owner A has had a conviction and has accepted the conviction: "Fine and dandy; thank you very much. It's only one conviction. I'm allowed two within"—it's after the second one, is that correct?

**Mr Williams:** Yes, that's correct.

**Mrs Haslam:** Okay. A couple of years down the road he sells the business. Another year down the road the new owner is convicted. It's the second offence in the same place.

**Mr Williams:** No, it's only the first offence for that owner in those premises.

**Mrs Haslam:** Okay, then I'm fine, thank you.

**The Vice-Chair:** Does anyone else wish to speak? You have before you Mr O'Connor's motion to amend section 15 by replacing it. All in favour of the motion? Opposed? Carried.

1500

**Mr Anthony Perruzza (Downsview):** Just for the record, Mr Chairman, I was in favour.

**The Vice-Chair:** Yes, I noticed your hand went up just as I was calling the other.

Section 16, government motion to amend.

**Mr O'Connor:** I move that subsection 16(2) and (3) of the bill be struck out and the following substituted:

"Forfeiture

"(2) Tobacco seized under this section is forfeited and shall be dealt with as the Minister of Health directs.

"Vending machine

"(3) The inspector's power of seizure includes power to open a vending machine in order to examine the contents, if the inspector suspects on reasonable grounds that the machine contains tobacco that is stored in a place in contravention of section 15, and no person is liable for damage done to the machine in connection with the opening.

"Money

"(4) Any money found in a machine containing tobacco that is seized under this section is forfeited to the Minister of Finance.

"Application of ss. 13(4) to (7)

"(5) Subsections 13(4), (5), (6) and (7) apply, with necessary modifications, to an inspector acting under subsection (1) or (3).

"Obstruction

"(6) No person shall hinder, obstruct or interfere with an inspector acting under subsection (2)."

This section allows for the confiscation of the tobacco in vending machines that are found in contravention of the legislation, which are subject to premises that are under automatic prohibition in the sale of tobacco as well.

**The Vice-Chair:** Any comments or questions? If not, you've heard Mr O'Connor's motion to amend subsections 16(2) and (3). All in favour of the amendment? Opposed? Carried.

Section 16, as amended, all in favour? Opposed? Carried.

Section 17, government motion to amend.

**Mr O'Connor:** I move that subsection 17(2) of the bill be struck out and the following substituted:

"Posting by inspector

"(2) If signs are not posted as required, an inspector may enter the premises without a warrant and post signs in accordance with the regulations.

"Application of ss. 13(4) to (7)

"(2.1) Subsections 13(4), (5), (6) and (7) apply, with necessary modifications, to an inspector acting under subsection (2).

"Obstruction

"(2.2) No person shall hinder, obstruct or interfere with an inspector acting under subsection (2)."

These, I guess you could say, are more on the technical side. They will allow an inspector the authority to enter premises and make sure that the signs are posted as required.

**Mr Jim Wilson:** Given the past three or four sections, I can see the real potential here for conflict. This subsection 17(2) deals with a new right for an inspector to enter the premises and stick up the signs that are required when somebody's convicted of having sold cigarettes to minors.

Going back to our scenario, the new owner of that corner store may not understand. One assumes, if I were convicted and wanted to ensure that the person coming to buy my store, because I've decided to leave for whatever reason—I'd take the bloody signs down that day and make sure he or she didn't see them. Then of course the



inspector comes along after I have bought the store and comes in with his hammer and nail and says, "By the way, this sign's supposed to be here and it's going to be here."

I can see real conflict if there isn't some sort of registry or some sort of change to the real estate act or something that requires disclosure that a conviction has occurred and that the premises are labelled for a period of time. This really reeks of big government, and you're setting up a potential conflict. It may be rare but—

**Mr O'Connor:** On that comment, during our time that we had the committee hearings, I believe we heard from the Retail Council of Canada. They had the opportunity to make comment if they saw a problem with this. The intent of this was in the legislation. This is more or less technical in the changes to it. The intent was there, and all these hypothetical scenarios that we've been discussing didn't seem to be a problem with them.

I guess there needs to be some reason when the inspectors are carrying out their duties, and I don't think they're going to be totally unreasonable people. At the same time, there is some responsibility in this as well.

**Mr Jim Wilson:** In defense of the Retail Council of Canada, they didn't have Mrs Haslam advising them, who has quite correctly pointed out that this scheme is a bit wacko, I think.

**Mrs Haslam:** I worry when Mr Wilson starts to compliment me.

**Mr Jim Wilson:** You think you worry?

**Mrs Haslam:** We're both worried. I know you're winning because I'm coming up with something else, but let me just trace back and say I'm sorry I brought this up. What do public health inspectors now have under their authority? They already have that authority to do that in restaurants. They already have that authority to close down Mr Wilson's butcher shop. Correct? They already have this kind of authority in other situations out there, and the idea that a restaurateur was going to sell his shop or the butcher was going to sell his shop to a new owner in between doesn't seem to be causing a lot of problems out there now. Are the duties we're giving them in this legislation similar to what they already have in other situations?

**Mr Williams:** That's correct. The reason we amended this section was to actually strengthen it from what we had in the original second reading bill, because as you notice, the subsections that are referred to in section 13 are ensuring that in fact the inspector does do things in the proper fashion. These are amendments that were suggested to us by the Attorney General as well.

**Mr Jim Wilson:** In the examples given by Mrs Haslam, I don't think counsel's correct in response. For instance, if your butcher shop is closed down for health reasons and you sell it, there's no period of—like, here the signs are posted for a period and the prohibition is for a set period regardless of who the new owner is. If it's closed down, you take remedial action.

**Mrs Haslam:** Immediate action? If an inspector comes in—

**Mr Jim Wilson:** If you're closed down for health

reasons and you sell it and the new owner comes in, presumably they can clean it up so they can get operating right away. There's no set time frame of prohibition that the shop must be closed because the knives were dirty that day. You take remedial action, you phone the health inspector, they come back and reopen you. Sometimes it takes an hour. Sometimes you clean up right in front of them—

**Mrs Haslam:** So they can close you immediately.

**Mr Jim Wilson:** —and they stand around smoking a cigarette or something waiting for you to start again.

**Mrs Haslam:** Do they close butcher shops and restaurants immediately?

**Mr Jim Wilson:** That was in the very old days.

**Mr Williams:** I think Mr Wilson's correct. Usually you're given some time to correct the situation, but I guess if it was a serious health hazard, they could close it immediately, if it was serious enough.

**Mr Jim Wilson:** Yes, they can, but also there's no statutory prohibition period.

**Mrs Haslam:** But there's a period of cleanup.

**Mr Jim Wilson:** You take remedial action and you get open again.

**Mr Williams:** I'm not quite sure how this relates to our section, though, to be quite honest.

1510

**Mr Jim Wilson:** The point was that you answered a question from Mrs Haslam, saying it was quite correct that the scenario was that a new owner has an inspector coming in and putting up signs because the previous owner left and ripped down the signs or whatever, and that was likened to the fact that health inspectors already have powers to do that sort of thing.

All I was saying was that under the powers Mrs Haslam referred to, you're permitted as an owner, a new owner or an existing owner, to take remedial action and get your store back open or to meet the order that's imposed by the health inspector. This one says that the signs will hang around for—

**Mrs Haslam:** It's my understanding that's—

**The Vice-Chair:** Please, one speaker.

**Mr Jim Wilson:** Let's make clear to the public that this one says that regardless of what happens, these signs hang around for a set period of time.

**Mrs Haslam:** But that's not what I understood. I understood that it was—

**Mr Jim Wilson:** Prohibition hangs around for a set period of time.

**Mrs Haslam:** But it wasn't that way, because the new owner wouldn't have to put up with those new signs because the previous owner was the one who had sold the business and therefore that wouldn't be a situation that he had to deal with.

**Mr O'Connor:** That's right.

**Mr Jim Wilson:** Is that right, now?

**Mrs Haslam:** Yes, that's the clarification I got the last time. That's why I don't have a problem with this one.

**Mr Jim Wilson:** Okay.

**The Vice-Chair:** Any further questions or comments? If not, Mr O'Connor's motion to amend subsection 17(2) is in front of us. All those in favour of Mr O'Connor's motion? Opposed? Carried.

Section 17, as amended: All in favour? Opposed? Carried.

**Mr O'Connor:** Mr Chair, we should probably go back to section 14 at this time. It was stood down.

**The Vice-Chair:** Revert to section 14, and Mr O'Connor had presented an amendment: further discussion on the government motion to—

**Mr O'Connor:** This is the one you suggested we stand down till we dealt with—

**The Vice-Chair:** Because it has a table attached. The motion by Mr O'Connor was that section 14 of the bill be struck out and the following substituted, and that had been read.

Further discussion on Mr O'Connor's motion on section 14? If not, all in favour of the motion? Opposed? Carried.

Section 18, government motion to amend, and I see that the previous one that was circulated has been replaced and is headed "Alternate 2, 4-CS." Is that correct?

**Mr O'Connor:** That's correct, yes.

I move that section 18 of the bill be struck out and the following substituted:

"Regulations

"18(1) The Lieutenant Governor in Council may make regulations,

"(a) prescribing anything that is referred to in this act as being prescribed;

"(b) authorizing the sale of tobacco in a part of a psychiatric facility for the purposes of paragraph 3 of subsection 4(2);

"(c) respecting the signs to be posted under sections 6, 10 and 17;

"(d) respecting the packaging requirements, health warning and other information referred to in section 5;

"(e) respecting the reports to be submitted under section 8;

"(f) requiring persons who sell tobacco at retail to submit reports to the Minister of Health;

"(g) defining 'video or amusement arcade' for the purpose of paragraph 9 of subsection 9(1);

"(h) establishing what constitutes a common area for the purposes of paragraph 9.1 of subsection 9(1) and defining 'enclosed shopping mall.'

"(i) prescribing criteria for the purposes of section 10.1.

"Same

"(2) A regulation made under clause (1)(c) may specify the wording and appearance of the signs and the locations where they are to be posted.

"Same

"(3) A regulation made under clause (1)(d) may,

"(a) impose different packaging requirements for different forms of tobacco;

"(b) govern aspects of packaging, including labelling, colouring, lettering, script, size of writing or markings and other decorative elements;

"(c) prescribe a minimum package size to contain not fewer than the prescribed number of items or not less than the prescribed number of grams of tobacco;

"(d) require that the health warning be inserted inside the package, printed on or affixed to its outer surface, inserted between the package and the outer wrapping, or printed on or affixed to the outer wrapping;

"(e) require that the other information be inserted inside the package, printed on or affixed to its outer surface, inserted between the package and the outer wrapping, or printed on or affixed to the outer wrapping.

"Same

"(4) A regulation made under clause (1)(e) or (f) may prescribe the contents and frequency of the reports.

"Same

"(5) A regulation made under clause (1)(i) may,

"(a) prescribe criteria relating to the size or location of smoking areas;

"(b) prescribe criteria relating to the floor space or permitted occupancy load of smoking areas as a proportion of the total floor space or permitted occupancy load of the place;

"(c) prescribe criteria relating to the ventilation of smoking areas;

"(d) prescribe criteria relating to the provision of equivalent or superior non-smoking areas;

"(e) prescribe different criteria for different categories of places.

"Effect of ss. (2) to (5)

"(6) Subsections (2), (3), (4) and (5) do not restrict the generality of subsection (1)."

Basically, these are some of the technical amendments and refer to some of what we discussed earlier.

**Mr Jim Wilson:** I have a question. I think I have the right version of this motion. It's alternate 2. One thing I notice that I don't recall talking about to any great extent is with reference to clause 18(1)(f). It's talking about "requiring persons who sell tobacco at retail to submit reports to the Minister of Health." I thought we had discussions about wholesalers and distributors of tobacco products having to submit reports, and I know there's a requirement for that but I wasn't aware of—well, I guess I was aware, because we did have a chat to some extent about the paper burden. Can you just explain to me what exactly these are?

I'm sorry; I'm a bit confused. I recall a distributor coming in and talking about the added burden of paperwork, but I don't remember retailers being told, in any of the previous circulations of this legislation, that they're now going to have to do another paperwork regime. As you know, as the government should be well aware, it's the paperwork and regulations and taxes that are killing our businesses in this province, and here we have the



Ministry of Health requiring more paperwork by small retailers who sell tobacco.

**Mr O'Connor:** Thank you for the question. We did hear from some people who felt that the reports we have in section 8—if we don't have compliance or have difficulty in getting reports because we may not be able to find all the retailers, there needed to be a way the minister could then go to the retailers. So I guess it's enabling at this point, because of some of the concerns that were pointed out to us by some of the people who made presentations to us.

1520

**Mr Jim Wilson:** What do you mean you can't find retailers? They submit taxes on these things through your revenue department. Can't you get off the backs of small business and just have government talk to government on these things?

**Mr O'Connor:** The intention is that we deal with the wholesalers on this. It was pointed out to us, though, by people coming to this committee that they felt that if there was some difficulty around section 8, which dealt with the reports from the wholesalers and distributors, then the minister should allow herself the opportunity to move forward in passing some requirements on the retailers. It's not the intention, but it's to enable the legislation to proceed. The intent of the legislation, as we've been hearing—that's why that presentation was made to us. It was with that concern, and that's what this amendment deals with.

**Mr Jim Wilson:** That presentation wasn't made by a retailer who's going to have to fill these out. Once again, you have people who have never run a bloody store in their lives dictating more paperwork for the small business community. I think that if that had been in the original circulation of the bill, you would have had the small business community coming forward and saying, "Look, some of us already have 36 or 40 reporting dates a year, and now there's a possibility that the Ministry of Health's going to want some more paperwork filled out by us, in addition to our employer health tax levy forms," which drive small business and in fact the business community of Ontario absolutely crazy.

Are you trying to kill jobs? It's bad enough that you've got wholesalers doing all this. They testified before this committee, if you want to go back to that, that they felt they were giving sufficient information now to the revenue department and that they didn't understand why the Ministry of Health needed more of the same paperwork filled out. Do you understand that paperwork costs jobs?

**Mr O'Connor:** The point is that we heard from people making presentations to the committee. They were concerned that the intent of the legislation, which has received a lot of support—that if you were to follow through with the intent of the legislation, we'd need to know who the retailers are. It's the hope that all this can happen through section 8 of the bill.

If section 8 of the bill proves to be problematic, that's why people came to us through presentations suggesting that the minister should be able to approach the retailers

for a report from them if that was necessary. It certainly isn't the intention of this government to make more work for the retailers, but the intention is that we've got 13,000 people in the province of Ontario dying needlessly from tobacco use and we're trying to protect the young people here. So with all that intention in there, we do need the ability to carry out the intention of the legislation that we all support.

**Mr Jim Wilson:** So you have to find out who the retailers are and you're going to have these people, and you don't know who they are, fill out reports. The only way you're going to find out who the retailers are, I suppose—I don't know—is to post a notice on hydro poles that, "The retailers on this street have to report to Big Brother whether or not they're selling tobacco."

That's crazy. You can't sell tobacco unless you remit taxes. You can't have a retail licence in this province unless you acquire one from the Ministry of Revenue. Why can't the Ministry of Health simply talk to the Ministry of Revenue to find out what retailers are selling tobacco products, rather than sending a pile of more forms out to retailers?

**Mrs Haslam:** It's not that specific.

**Mr Jim Wilson:** No, the information there, Mrs Haslam—

**Mr O'Connor:** I guess the key here is that there are a lot of retailers in this province. We heard even from some retailers who don't sell tobacco products through the course of these hearings. There are a whole host of retailers. Not all retailers sell tobacco products. I guess the key here is that it's the tobacco products we're trying to deal with. We're not trying to complicate it. What we're trying to do is be able to conform to the intent of the legislation. To do that, we're putting in an enabling portion here that will allow the minister to approach the retailers if it's necessary.

**Mr Jim Wilson:** I don't understand it. I've still not heard an explanation to justify the enabling action here. You can't sell tobacco legally in this province unless you remit the tobacco tax back to the province and the feds, so you know already who's selling tobacco, legally anyway. Anyone selling it illegally isn't going to fill out a report anyway.

**Mr O'Connor:** I guess maybe I could ask for a clarification, but I don't know whether—

**Mr Jim Wilson:** I think it's the bureaucrats thinking they need another report and not in any way understanding the amount of paperwork and the job losses that have occurred in Ontario because of our overregulation and paper burden on the business community. If you can avoid another report, I would simply ask you to do so. If you can get together with the Ministry of Revenue and avoid this at all costs, you should take it out of the legislation.

**Mrs Haslam:** I apologize, because I was out of the room when this started, but section 8 deals with "A person who, in Ontario, sells or distributes tobacco for subsequent sale at retail." So it's not a retailer. It's not your corner store that has to fill out the reports.

**Mr Jim Wilson:** No, it's 18(1)(f), Karen.

**Mrs Haslam:** Yes, but 18(1)(e) says—oh, I see what you're saying, 18(1)(f).

**Mr Jim Wilson:** Then (f) says again you've got to fill out a report.

**Mrs Haslam:** To sell tobacco, to submit a report. I stand corrected.

**Mr Jim Wilson:** That's new. That wasn't part of the hearings.

**Mrs Haslam:** Yes.

**Mr Jim Wilson:** They slipped that in. I noticed it last night.

**Mr O'Connor:** I don't believe that at this time each individual retailer submits their taxes on tobacco individually. I believe that's done through the wholesale avenue and through the distributors.

**Mr Jim Wilson:** You're already asking wholesalers for those reports—

**Mr O'Connor:** That's right.

**Mr Jim Wilson:** —and you want more detail in those reports. You've won that battle. Now why do you have to go after the retailers?

**Mr O'Connor:** What was pointed out to us was that if there are problems in that area—and the detail is not about the amounts of tobacco—we can then take a look at other elements of it if we don't have that information. We may need this extra authority. So we've put in this section the authority that's been asked for by people who came to the committee.

**Mrs Haslam:** If and when needed: Is that the gist of it?

**Mr Jim Wilson:** It's always if and when needed, as you know, and if and when needed in government means it's always needed, and it always ends up in the paper stream eventually.

The point is that you've got tough legislation now, when this passes, to require reports in whatever detail you prescribe from wholesalers. Am I correct? Including where in the world they dispose of their cigarettes, who they sell cigarettes to.

**Mr O'Connor:** Correct.

**Mr Jim Wilson:** So why don't you just enforce that section, which we've already given you in previous voting, or we will be giving you, which I think is punitive enough, but there's fewer wholesalers and I think we had some commitment during the hearings that Health would try not to be too punitive in this area and would try and get together with Revenue. At least that's the discussion, we were told. Now why at the 11th hour do you have to slip in paperwork for retailers, when if you simply used the wholesaler scheme you thought up, you should get all the information and more than you can possibly need for the sale of cigarettes in the province of Ontario?

**Mr O'Connor:** I can only point out that through the course of our hearings, we had concerns brought to our attention that they felt that if there were problems there, the minister should then have the authority to go to the retailers, and this will allow the minister to do that.

I agree that in the scenario you presented in section 8

that would be the best approach, and I'm sure that's the approach that will be taken to begin with. It was just in addressing some of the concerns as pointed out to us through the course of our hearings that this section was amended this way.

**Mr Jim Wilson:** I just beg to differ. I don't require retailers begging for this or anyone else; I require people talking about the reports that wholesalers had to fill out, and I thought that was a bad enough paper burden, but there aren't that many of them in the province and part of the condition of selling the product would be that. But now you're adding a whole new stream. Don't tell me it won't be used. Government doesn't go around asking for prescribing powers it doesn't intend to use or hasn't already thought of a reason to use, and you haven't given me a good reason yet.

Has the Treasurer been asked his opinion on this? Has Mr Rae, the Premier, been asked his opinion on this, more paperwork for small business? It's not what I'm reading in his speeches these days.

**Mr O'Connor:** This is to address some of the concerns we heard. We want to move forward and make sure we can uphold other sections of this bill so that the intention that has been brought to us—for all the people who came to us applauding what we have to do and the way we need to do it, we need to make sure that we have the tools to enable us to do it. The intention is to use section 8, and the concern is that if there are some problems there, the ministry would like to be able to then go directly to the retailers and work with them. Not every retailer in the province; just the retailers of tobacco products.

1530

**Mr Jim Wilson:** You're hardly going to work with them. It's a witchhunt clause, that's all it is if you don't trust wholesalers to give you the information, even though you can penalize them if they don't give you the proper information. You've already got another information stream and that's the revenue department, and now you're giving yourself a witchhunt clause that says there might be a few more other retailers out there selling cigarettes. I don't know how in the world they would sell cigarettes without a retail licence and without submitting the tax back, and there's a paper trail on the tax.

I just think that in your good graces you should rethink clause (f) here and take it out unless you have an absolutely concrete reason that you need it, and you don't. If you'd just open your eyes and look at how government works, you don't need this prescribing power. You've got more than enough information that 93,000 bureaucrats can't possibly digest right now.

**Mr O'Connor:** Mr Chair, through you to the honourable member, as we go through this, and realizing that this is a health piece of legislation and always keeping in mind that we want to deal with things in a local fashion when it comes to some of the health issues as presented to us—that's why we heard from so many people involved in the health promotion elements of this—I think it could be that somewhere down the line we may want this information for work within the community as well, and this would allow us perhaps an opportunity to



deal with health promotion on a local level. Again, all I could point out is that there were concerns pointed out to us through the course of the hearings and we're addressing them.

**Mr Jim Wilson:** Let's be a little more specific, then. What kind of report are they submitting? Now they're going to help you do health promotion reports on a community level or something?

**Mr O'Connor:** No, the key here is that we—

**Mr Jim Wilson:** It's not their job, by the way. They might do it out of goodwill, but the minister could simply write a letter to them saying, "I'm the Health minister and I'd like your help in your community to fight tobacco among young people." You're requiring reports here. You're requiring paperwork. If there's one thing that's very clear to everyone in this province, it's paperwork that's killing the jobs in our province.

**Mr O'Connor:** I realize that, Mr Wilson. In fact, I heard through the course of these hearings suggestions by your party that we extend liquor licensing and create some more bureaucracy in trying to deal with other elements of this legislation.

**Mr Jim Wilson:** I agree and that's why we backed off that.

**Mr O'Connor:** Then at that point I realized that you wanted to back down, realizing you didn't want to place some extra burden on these establishments.

Here again, the fact of the matter remains that section 8 is the portion of the bill where we're going to work with the wholesalers and distributors to have these reports. As pointed out to us by presenters to this committee, they felt the minister should allow herself the authority through this section that to go to the retailers and work with them to have reports filed if they were having difficulty.

**Mr Jim Wilson:** I give up.

**Mr McGuinety:** I want to support Mr Wilson's objections raised to the inclusion of clause (f) in subsection 18(1). First of all, it's a surprise. Retailers were never made aware during the course of the hearings that the government was considering making them file reports of one kind or another. I get the impression that it's kind of a back-door effort to implement some form of licensing. If we're going to talk about licensing, then let's talk about licensing. If that's what the government's after, then let's talk about licensing.

In fairness to people who were never told that this was part of the agenda, who have never had an opportunity to express their concerns about it—I know what they'd say. I'd say they've already got enough paperwork, period.

I think that retailers can be encouraged to become a partner in health care. I'd like to see everybody in the province become a partner in terms of promoting health care. But I just don't see the necessity for the inclusion of clause (f) here, and I don't think that passing a new section 18 with it is fair to the people who should have had an opportunity to respond.

**Mrs Haslam:** This is an interesting argument. I'd like some clarification, because I've been informed, and I'll ask legal counsel about this, that the revenue and taxes

are collected from tobacco wholesalers, that the revenue and taxes are not recorded in the revenue ministry for retailers, so there may be a problem in getting a good list of retailers because of that, plus the fact that a wholesaler may sell to a larger corporation that then distributes to a smaller number of stores. That would preclude us from getting that list of retailers. If those two reasons keep us from having an up-to-date list, that's why you've given the authority, should that happen, so that we can get a good list of retailers who sell tobacco. Am I correct in those things?

**Mr Williams:** Yes, that is correct. In fact, for the tobacco taxes that are collected, it's an indirect tax. It's not collected directly from the retailer. The retailer will reimburse the distributor from whom he or she buys the tobacco, but it's the tobacco wholesaler-distributor that submits the taxes to the Ministry of Revenue.

The other complicating factor, as Ms Haslam has pointed out, is that a large drugstore chain usually has its own distribution centre where it may get tobacco from the tobacco wholesaler and then in turn distribute it to their individual stores. The chain of information tends to stop at that distribution unit. Our hope is obviously to try to get that information from the wholesalers and distributors, but if for some reason we can't, we want to have the ability to go a step further.

**Mr O'Neill:** I'm having quite a bit of trouble with this as well, mainly because of the lack of consistency between section 8 of the bill and section 18 now. I realize that you can make regulations on anything you want to, but I think it's quite deceiving to have in the body of the bill under section 8 that the person who's going to submit reports is going to do it for the purposes of being a wholesaler, or in the position of being a wholesaler, in that the person is described as one who would be selling "for subsequent sale," and now we get "requiring persons who sell tobacco at retail" in section 18. In my mind, if the government was going to do this, it definitely should have changed section 8, which it didn't.

I feel quite strongly, therefore, that I would like to have an amendment to the amendment placed in my name that we remove clause 18(1)(f) from this to make the regulations consistent with the act.

**The Vice-Chair:** You're moving an amendment?

**Mr O'Neill:** I am.

**The Vice-Chair:** Discussion on the amendment?

**Mr Sterling:** It is kind of strange that something requiring somebody to report is in the prescribing section of the bill. Normally in the prescribing section of the bill you are further defining sort of the details of what is required of people and citizens and government in the main body of the bill. Therefore, really, if it's the government's desire to do this, it should be dealing with section 8 and not with section 18.

**Mr O'Connor:** If I might, perhaps we can ask legal counsel whether or not this section requires that section 8 should have been amended to deal with the wishes that have been presented here. Should we have amended section 8 to allow us to put this in section 18? Was it necessary?

**Ms Filion:** No, it wasn't necessary. You can give yourself a fairly broad range of powers in the regulations. 1540

**The Vice-Chair:** Do you wish to continue, Mrs O'Neill?

**Mrs O'Neill:** Yes, I do. That's what makes regulations so difficult. We're affecting literally thousands and thousands of retail outlets in this province with this regulation. Aren't we lucky that we were able to find it out at this moment, because there likely will be further regulations later, but it wasn't part of the hearings. In no way did the retail industry know it was going to have to do this. They're used to dealing with this government through their wholesaler, for the most part.

I'm sure most of us have talked to retailers. I've talked to them lately because they're quite upset, and I'll bring this to the table right now, that they're not getting the rebate on the tax from this province that they've paid up front for the cigarettes that are on their shelves right now, and they are having to sell them at less than they paid for them. That is a hardship for the small businessman. I'm talking about a store that's about as big as my bathroom. I've had two complaints from my riding on that issue already. Anyway, that's another matter.

That's the way they're used to reporting to the Ministry of Revenue and paying the Ministry of Revenue, and now the Ministry of Health is going to ask them for something else. It's never been brought to their attention till this afternoon, at this moment in this hearing, and most of them wouldn't even be interested in listening to this, because they don't think it affects them.

**Mrs Caplan:** What's driving small business people crazy in this province is the need to fill out government forms. The thought of yet another government form is just unreasonable. I don't know why you have to have this in this legislation at this time. The one complaint that I hear over and over again from small business people in this province is that the regulatory burden from the provincial government is driving them up the wall, is driving them out of business, is forcing them to distraction and frustration, and certainly is not helping create jobs in this province. The cost in time and effort to fill out government forms and reports is something which small business in particular is just going wild about.

I would urge the parliamentary assistant and the minister to send a very important signal to the small business community in this province and remove clause 18(1)(f) from the regulatory reporting requirement of the Ministry of Health on this matter. There are numerous other reports that are being filled out already, and frankly this one is just absolutely and completely unnecessary. It's an unnecessary regulatory burden. It's one more thing that's going to make small business mad. It's going to affect our ability to encourage job creation in the private sector and encourage small retail business in this province.

Whether it's tobacco sales or anything else, they will see this as yet another government form. It's the wrong signal and I would encourage you to take the very sensible suggestion of my colleague the member for

Ottawa-Rideau and take out clause 18(1)(f).

**Mr O'Connor:** To the honourable member, the key here is that there needs to be auditing. If we take a look, for example, at the OHIP system, the OHIP system has its own checks and balances that are in place. Very rarely do you go to the patient and ask, them, "Have you been to Dr X, x number of times over the course of the last set period of time?" But OHIP does do that on occasion. On occasion, they do go to a selected few people within the province with a report that says, "We have had claims on your behalf for medical services that have been rendered to you by Dr X." It's a checkpoint; it's a check and balance. Every system needs to have checks and balances in it.

Now we have a situation where we have wholesalers that through section 8 of this will be filling out reports to the Minister of Health that will allow us to track the sale and distribution of tobacco. The intention is that that's where we're going to be dealing with this. What we won't have if we strike this out is that check and balance, that opportunity for us then to go to a retailer on occasion and say, "Is this within what we're doing?"

What we're not trying to do here is place an undue burden on small businesses, as we have heard; in fact, this is one of the governments that reduced taxes to small businesses. This government doesn't want to do that. What we want to do is try to allow ourselves a place where we can have a check and balance, and that's what was presented to us as we went through the committee hearings. That's why these people made this suggestion that this check and balance be put into this legislation.

**Mrs Haslam:** As I understand it, "The Lieutenant Governor in Council may make regulations...requiring persons who sell tobacco at retail...." Is it the intent that it be done in regulations immediately? As I understand it, the intent is to go to the wholesaler, to the distributor. That's where your revenue lists are; that's where your tax lists are. You don't have a list of businesses out there through revenue or through taxes that sell tobacco.

If that doesn't work, what this allows you to do is to go further in trying to track the sale of tobacco, but it isn't a given that this will be done. That's how I'm reading it. I'm reading it that we're going to go for clause (e), "reports to be submitted under section 8," which is wholesalers and distributors.

If you don't get the information about who is selling tobacco out there, if you need to know more about the tracking of where that tobacco is sold, without this you have no comeback: You don't have anything in the Revenue ministry that tells you where it's sold and there isn't a licensing process in place, so you don't have the possibility of finding out what retail outlets sell tobacco. Is that the case?

**Mr O'Connor:** If I can assure you to some degree, when the regulations are introduced and proclaimed, the intention here is that we're going to go with section 8. That's where we're going to be dealing with it. We're trying to deal with it at the wholesale and distribution levels. It's not the intention to go to the retail element



unless we find difficulties. What we're asking here is that should we find that we have some difficulty, we have the authority that we can go to the retailers, if that is the case down the road.

There are some real concerns that some people within this industry have some interesting ways of dealing with reporting, and it's the intention that we have a way of validating things down the road and offer some protection for the intention of what we have in this legislation.

**Mrs O'Neill:** I think I have to make a correction. I do not think Ms Haslam was correct when she said the Ministry of Revenue will have no record of who sells tobacco.

**Mrs Haslam:** No, I said not retail; they have a record of wholesalers and distributors.

**Mrs O'Neill:** And they have a record of the retail through the wholesale.

**Mrs Haslam:** I asked for clarification from the legal—

**Mrs O'Neill:** That's really quite confusing. The wholesalers must have it, because I actually saw the forms when I talked to—

**Mrs Haslam:** Not the retailers.

**Mrs O'Neill:** —with the person who's complaining about the rebate. I saw the forms myself that must be submitted by the retailer to the wholesaler regarding submission of tax.

**Mrs Haslam:** Ask for clarification, because that was the question I asked.

**Mrs O'Neill:** There is nobody from the Ministry of Revenue here at the moment.

**Mrs Haslam:** Isn't that what you were indicating to me?

**Mr Williams:** The information that I have been able to obtain from the Ministry of Revenue legal branch is that where the distributors sell to individual store owners, certainly there's no problem. But there are instances with chain stores where the sale from the wholesaler or distributor is to the chain store, which has its own central warehouse where it sells to its individual stores. That's not considered a distributor in the normal sense, and there's no way of the original wholesaler or distributor knowing whether store A or store B of that chain gets 10 pounds or 200 pounds of tobacco, and that's the problem.

**Mrs Haslam:** How are taxes rebated, through the wholesaler or the distributor or through the retail outlets?

**Mr Williams:** The retail outlet basically pays to the distributor what it has sold in the way of tobacco tax, but it's collected—

**Mrs Haslam:** And they are the ones who report to Revenue?

**Mr Williams:** From what I understand, the tobacco tax is collected at the wholesale-distributor level.

**Mr O'Connor:** So at that point there is no record within the government of Ontario of who the retailers of tobacco are in the province.

1550

**Mr Williams:** The thing that is confusing to every-

body, and I admit it is confusing, is the fact that the Ministry of Finance does collect provincial sales tax from vendors, but the vendor's permit that a retailer has does not indicate whether in fact it is a seller of tobacco. They used to, I think, 20 years ago; they don't any more.

**Mrs Haslam:** There's no accurate list.

**Mrs O'Neill:** Here again we have the bulldozer on the mosquito, because you're talking about 120,000 and most of these are small. We know the big guys. This Minister of Health has just hired 50 police on cigarettes. We just had that happen last week. Talking about checks and balances, how belaboured are the retailers going to be? They've got this police squad out there. Now they're going to have to have reports. They are already licensed as retailers. Most of them belong to retail councils; they belong to the boards of trade and chambers of commerce. These people aren't all crooks. I'm really getting tired of the way you're talking about the business people of this province and saying that they have to be looked at from every single direction. We're going to have a whole—

**Mr Perruzza:** I resent that. Point of order, Mr Chair.

**Mrs O'Neill:** Well, I'm sorry, I have the floor. We have Bill 119, which is a very—

**The Vice-Chair:** Point of order, Mr Perruzza.

**Mr Perruzza:** My point is this: Ms O'Neill has implied that the government side—

**Mrs O'Neill:** That is not a point of order.

**Mr Perruzza:** —has referred to small businesses in the province of Ontario—

**Mr Sterling:** No, you just treat them like that.

**Mr Perruzza:** —treating small businesses in the province of Ontario as crooks. That's absolutely untrue and, quite frankly, a bold-faced you-know-what. I would ask you, as Chairman of the committee, to ask Ms O'Neill to either clear that up, get it off the record or fix it in some way, because that's not true. We've done more for small business than they ever proposed to do when they were in government. They just taxed them out of existence. That's what you did. You taxed them out of existence.

**Mrs O'Neill:** And you're driving them.

**The Vice-Chair:** Mr Perruzza, thank you for your participation. Ms O'Neill, would you please continue.

**Mrs O'Neill:** I feel very strongly that people are not being treated fairly. They're not being treated with the dignity that they need. They're not being encouraged to hire even part-time people. We had very responsible business people come here and tell us how they were going to implement Bill 119. Let's see them do it instead of imposing further impositions on to their line of business.

**Mrs Caplan:** I would very much like to make a helpful suggestion. The one thing that business is saying is that we are overregulated, that one ministry doesn't talk to another. Why don't you simply amend the form from the Ministry of Revenue, if there's additional information that you require, rather than having a new and additional other form from the Ministry of Health? Let's get serious and let's get sensible here. Cut it out.

They don't need to fill out yet another form. You are not doing anything but frustrating them.

**Mr O'Connor:** The fact of the matter is that while we were dealing with this issue we went to the ministry and asked whether or not there was a way of doing that in the reporting systems. There wasn't. So what we're trying to do here is put in that check and balance. As a former Minister of Health, I'm sure she realizes that there needed to be a check and balance when we deal with the Ministry of Health and the OHIP system. There is that check and balance which allows the ministry to go to an individual and ask whether or not they have been in receipt of different benefits through the health care system that are to be paid for on their behalf. It's not something that's done all the time and not every person in the province of Ontario goes through this check and balance.

What we're not doing with this, and I'll state it again for the record, is that we are not requiring every retailer in the province of Ontario to fill out a report. What we are doing at this point is addressing the concerns that were brought to this committee that should section 8 of this bill prove to be problematic, should section 8 of the bill not provide the detailed information that would be necessary, we have the ability to put in that check and balance that would be necessary so that we can fulfil all the rest of what we want to do through the retail of tobacco through the province of Ontario.

It is not the intention at this time, and when regulations are proclaimed it is not the intention, that there will be massive reporting by all the tobacco retailers in the province of Ontario. But what we need is that check and balance, so that we have the intention, the fine intention that all the members of the Legislature have in this legislation, that we have that ability to move forward, so that we can move forward and try to slow down that rate of the 13,000 people who are dying from tobacco-related illnesses every year, that we have that ability to put in there what we want as the intention.

The intention here is that should section 8 not give us the information that's necessary, should that prove problematic, then we have an avenue open to us to go to the retailers and work with the retailers to establish a reporting system from there. When the bill and regulations are proclaimed, it's not the intention that every retailer in the province of Ontario who sells tobacco is going to be subject to filling out a report.

**Mr Sterling:** I have a question for the parliamentary assistant. Under the retail sales tax, retailers are compensated for filling out the retail sales tax and submitting it. Is it your intention to compensate retailers for filling out this form?

**Mr O'Connor:** At this point the wholesalers are the ones who fill out the form, not the retailers. The retailers at this point do not remit to the Ministry of Finance the remittance that is required. It is something that is done through the distributors and the wholesalers.

**Mr Sterling:** But for other products that they sell in their stores, when they remit a retail sales tax form, they get paid for doing that. They receive compensation for doing the government's business, providing it with information. Are you going to compensate them for doing

this additional burden of work that you're requiring of them? Are you going to compensate them?

**Mr O'Connor:** At this point, there is no intention of having them fill out this report, and then—

**Mr Sterling:** You can't have it that way, sir. You either deal with the issue or you take it out.

**Mr O'Connor:** Thank you, Mr Chair. I thought I had the floor there.

**The Vice-Chair:** Yes.

**Mr O'Connor:** I appreciate that. The intention isn't that all the retailers in the province of Ontario aren't going to be filling out reports.

**Mrs Caplan:** That's a double negative that suggests that they are.

**Mr O'Connor:** My grammar's being corrected here. Thank you. I'm afraid I don't have a degree in English; sometimes my English may fail me a little bit. I appreciate what the concerns are. The concerns are that there is going to be undue hardship placed on retailers by their filling out reports on a constant basis on the tobacco sales they're going to have.

Let me state for the record, again, and I thought I did it already, that it is not the intention that every retailer of tobacco is going to be filling out a report daily, weekly or monthly. It is the wish that we can deal with it through the distributors, through section 8, the wholesalers. Should that section be problematic—and it was pointed out to us through the committee hearings that there was a concern that if this fails, how is the minister then going to be able to comply with all the good intentions that we have in this legislation? If that's the case, how can we do it?

This is the way we can do it. The day that this act's proclaimed, we're not going to, all of a sudden, require all of the retailers in the province of Ontario to be filling out report after report after report. But for us to be able to comply with the legislation, to deliver on the intent of the legislation, so we can proceed with what we wish in this case, we do need to have that ability. That's what we have here. The compensation package that the member's referring to would be the same level as what we see with the GST.

*Interjection.*

**Mr O'Connor:** It's not there? I'm sorry it's not there, but there's not a huge reporting thing we're talking about. This isn't anything like the GST. It is very problematic and is a heavy burden on retailers, I agree. We're not talking about that type of reporting, so I don't think that we can move with that. In fact, if the member were to move something requiring compensation, I'm sure it would be ruled out of order.

**Mr Perruzza:** Well said, in very good English.

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**Mr Sterling:** The parliamentary assistant is presenting what I would call a ridiculous situation. He's saying we don't need this section unless section 8 doesn't work. I say to you, sir, that as a parliamentarian I have the right to consider this when in fact it's going to be used. I don't want to pass laws that are going to be kept in abeyance



by a government to just sort of pull out of their pockets whenever they need to fire the gun.

You come back to the Legislature and have this section passed. That's what the Legislature's supposed to be here for. You pass laws when they're timely and needed; you don't pass laws, "If this doesn't work, then we're going to try this, or then we'll try that." You don't create laws in terms of either you're certain of your action or you're not certain of your action. When you're certain of your action, come and talk to us, and then we'll talk about whether we pass this law or we don't pass this law.

If you're not going to use this section, then why don't you put some compensation in for people who fill these forms out? In my view, it would be very much less likely that the government would require this report if in fact a compensation tag was attached to it.

In other words, the bureaucrat or the minister, who some day down the road decides, "Well, I've got the power. Let's say, for the sake of research, that we require these retailers to make a report"—that's fine and dandy for someone to consider that when they're not paying for it. "Sure, let's require it. Let's dump this burden on all of the 120,000 retailers who are doing it." But if there is compensation attached to requiring that particular piece of paper, then they're very much less likely to take the decision lightly.

Therefore, I would ask the parliamentary assistant to consider very seriously putting some compensation attached to this requirement, as is the case with the retail sales tax.

**Mrs Caplan:** The taxpayers want government to streamline its operation. They have an expectation that ministries will work together to solve problems. My constituents tell me that they can't understand it when one ministry and another ministry won't cooperate and work together.

You are the government. You, your ministers and your Premier have the ability to say to the Ministry of Revenue, "Here are some additional data we'd like you to include on your forms because the Ministry of Health needs this information." You can do that. You can do it without a new regulation specifically for the Ministry of Health. You can direct the Ministry of Revenue to provide the Ministry of Health with the information that it requires. You can require that ministries work together.

I've been listening to your arguments and I don't think there's any guarantee, once you have this regulatory power, that you're not going to simply burden small business with yet another form. Once you have that power, it is in the interests in bureaucracy to justify their own existence and send out the requests for the information.

It is additional work for small business and it is additional work for civil servants, and it will have a life of its own unless you take the leadership as the government and say: "We're going to cut this out. We're going to reduce the regulatory burden. We're going to streamline government. We're going to make sure that ministries not only talk to each other but work together."

The first step towards doing that is to remove clause (f) and this requirement for yet another form to be filled

out, to be sent to the Ministry of Health, when a form is already being sent to the Ministry of Revenue. For you to say that the Ministry of Revenue says they can't change their form, I can tell you, sir, both as a former minister—Minister of Health—and presently the Revenue critic, to me your response is absolutely unacceptable. You can tell the Ministry of Health that the Ministry of Revenue can work with them to provide that change.

It's interesting because your Finance minister is the Minister of Revenue. He is the chairman of your treasury board. They are supposed to be looking for ways to make government more efficient. Here is an example of something that you can do that is very simple, and I ask you if you will not, today, take the first step towards sensible government.

**The Vice-Chair:** Do you wish to respond at this time?

**Mr O'Connor:** I guess I could respond to the very direct questions that she's asked here. It makes sense that the Ministry of Health would go directly to the Ministry of Finance and have this discussion. In fact they have had that very discussion. It is a result of some of that discussion which pointed out the fact that the Ministry of Revenue doesn't get these reports from the retailers as suggested. After hearing from the Ministry of Revenue that we don't have this reporting take place now, what the minister wants to achieve through section 8, if that can't be achieved, is to have the ability.

What we are hearing here today is that the two ministries should talk. One ministry should go to the other ministry and tell them: "Let's start doing it even if it isn't required today. Let's start making every retailer in the province have to report." That's not what we're trying to do. That's not the intention.

What she's saying, in saying that the two ministries should work together, has in fact happened. The two ministries have got together and talked and that's why we found out that every retailer in the province of Ontario that may sell tobacco doesn't report directly to the Ministry of Finance. It doesn't happen that way.

What we're asking here, then, is for an increased burden to be placed on them immediately, and I don't think we want to do that. I don't think we want to place that increased burden on them immediately. Should section 8 of this bill not provide the information necessary, and should it be necessary, we are asking for the ability to then go to the retailers and work with them.

What she's asked for actually has happened. We've had that opportunity to go and have the two ministries—many ministries, as you can see, Mr Chair, through the course of the day's hearings. We've heard suggestions made by different ministries and some amendments taking a look.

Actually, there have been many ministries involved in this discussion. When the suggestion is that the two ministries work together, in fact they have worked together. It's because they've worked together that we found out that this reporting doesn't take place at this level. It doesn't; it takes place at the distribution level; it takes place at the wholesale level. That's where the

tobacco tax is. For us to then go to every retailer and add more paperwork to them I don't think would be fruitful. We're not about to do that. That's why I state that we're not about to proclaim that as part of the bill here. Should we need that ability, as was presented to us by the people who came to this committee saying that the intention of the bill is fine but what happens if the wholesale information doesn't provide you with the detail you need, how are you going to deal with that? Shouldn't you then at least give yourself the authority to go to the retailer? That made a lot of sense.

Not wishing to place a lot of undue burden on the retailers, we haven't placed that as a primary concern in the bill, and that's why there's not another section in there in section 8, saying all retailers are going to have to report. What we're doing here is trying to put in a little bit of sense that will allow us, with the intention of the legislation, to move forward.

All ministries that are concerned have had the opportunity to actually come to the table, sit down, discuss this in a reasonable fashion, and the ministries have decided that the best approach would be, if necessary, that we need to have that authority. That's why we've got it in section 8 here.

**Mrs O'Neill:** The more Mr O'Connor speaks of this, the harder I can accept it. It's with the greatest of difficulty that I'm accepting his arguments.

We had a very big problem in this province, I think it was in 1988, when ministries had to sit down and draw up a French-language voters list. That was a heck of a lot more complicated than what we're doing now. We worked day after day. I happened to be part of that and it wasn't easy. But we came up with a new enumeration form in this province that's acceptable and we publicized it and people got on the right voters list.

I have seen the forms of which you speak. I do not believe they cannot be corrected, adjusted, amended; I just don't believe it. If the will was there it would happen.

1610

I have so much trouble when you as parliamentary assistant and/or a minister—and I'm thinking again of the war in the media now between the chairman of the school board in Scarborough and the Minister of Education, which I think is just disgusting because it involves an individual student, and that's what it's come down to, and there are going to be other individual students involved—where a minister now is interpreting an act on his own that lawyers for the board have interpreted another way. I was also part of that piece of legislation.

You're telling us when and how this is going to be used. It doesn't say a thing here that you're going to use it if necessary. It doesn't say a thing here that you're going to use it for auditing purposes. Auditing purposes are very different than what you're describing. Auditing purposes usually happen at the most on an annual basis. You don't suggest here that it'll be on an annual basis. You don't suggest what the purposes are.

You talk and talk and talk about checks and balances. You talk about some army of bureaucrats that are going

to gather this information some day. It's just really deplorable that small business is going to sit down and all of a sudden think that it has something else to do. They're going to feel obliged to do it and they're going to wonder when they're going to be hit on the head with the hammer.

I really don't see how you can keep this in here in conscience unless you amend it to say exactly what you've been saying this afternoon, and my motion stands until you present something else that goes for clause 18(1)(f) that is more clarified for the purposes you have been expounding and expounding.

**Mr McGuinty:** Just to come back the issue before us, Bill 119, basically it's a good bill. There are some difficulties that I personally have with it but on the whole it's a good package, and it's unfortunate that what the government has done has muddied the waters with this particular provision.

You know, you don't want to turn a silk purse into a sow's ear. You don't want to give all of this a bad name. I don't want the only thing that comes out of Bill 119 to be, if I'm a retailer, "Isn't that the bill that those people down at Queen's Park passed which is going to make me fill out another form?" I don't want that to be the message that is sent by Queen's Park when this becomes law.

I can't really believe that the government didn't recognize what this is all about. This is like waving a red flag in front of a bull.

**Mrs O'Neill:** Exactly, exactly.

**Mr McGuinty:** This is 1994. Our small business people have just managed to pick themselves up to the point now where they are on their knees. They are just barely able to make ends meet. They deal with something that is foreign to many of us called overhead. If they're sick, overhead goes on. They have costs. Not only do they not get paid but they have costs, and government has put all kinds of obstacles during the course of government, and I'm quite prepared to say that we have during our term added to that, but that's history.

Now we have an opportunity before us to address this issue and what we can do in a very real way in terms of helping. Rather than doing something to them, let's do something for them and let's ensure that we're not adding burdens in terms of paperwork, let alone government costs that will be associated with collecting this kind of paperwork and reviewing it and doing whatever, God knows what, with it. Let's get this out of here.

My colleague Ms O'Neill has put forward I think a very reasonable motion and Mrs Caplan has spoken wonderful words of wisdom on this based on her experience in these matters. Let's get on to the important part of section 18, which deals with generic packaging. I think we've spent a lot of time on this. Let's yank this part. Let's get on with it.

**Mrs Caplan:** I really have said everything I want to say on this. My view, if the government insists on moving ahead with this, is that it really is an example of just incompetence and not understanding how the world has changed.

**Mr O'Connor:** I don't know if this could be simply



amended by adding something that may appease what I'm trying to state here as the intent; if we could add to the end of that amendment the words "if necessary," if that would help. The key here is that it's not the intention we're going to move forward with it and have reports happening all the time but to show the intent here is "if necessary." That would allow us, then, to show that it's not going to be a requirement that's going to happen all the time but just if it's necessary.

The difficulty we have here is should we have problems with section 8. I don't want to put a lot of extra words into the legislation. I know that does complicate our lives, and we've certainly had enough complication in dealing with clause-by-clause, but if the words "if necessary" were added to that clause. Perhaps before I make that suggestion that I think may help alleviate some of the concerns that are presented, we should have a little bit of discussion on that.

**Mr McGuinty:** I'm sorry, just to confirm, you want to add the words "if necessary" to—

**Mr O'Connor:** To clause 18(1)(f).

**Mr McGuinty:** That doesn't lend any comfort to me at all, because "if necessary" is purely subjective. What may be necessary to you may not be something that I deem to be necessary whatsoever. To some people, to go through a day it is absolutely necessary that they have a cigarette; to me, it's not necessary at all.

**Mrs Caplan:** What is necessary is for the Ministry of Health to work with the Ministry of Revenue. That's what's necessary. What's necessary is for government to streamline regulations. That's what necessary.

**Mr O'Connor:** I'm glad you pointed that out, because that's what I said, and we've done that.

**Mr Perruzza:** We're trying to address five years worth of Liberal incompetence.

**The Vice-Chair:** Mr Perruzza, sorry, you do not have the floor. Mr McGuinty, would you continue, please. You have the floor.

**Mr McGuinty:** I always appreciate Mr Perruzza's interjections. The long and the short of it is, that doesn't lend any comfort to me, and I think that we should simply remove clause 18(1)(f) in its entirety.

**Mr O'Connor:** I appreciate that. I think that what I've offered was perhaps something that could be a compromise. I'll ask legal counsel if they can think of something that perhaps might appease some of the concerns that are being presented here. I think I've stated clearly that it's not the intention we're going to have reports flying out of these retailers all the time.

**Mr McGuinty:** If it's not the intention, then let's pull it.

**Mr O'Connor:** But that not being the case, we still need to have that ability should section 8 be problematic. So I'd ask our counsel, Mr Williams. Frank, if you could help us, give your thoughts on what I've made as a suggestion and maybe something else.

**Mr Williams:** I've just spoken to legislative counsel. She's got all my handwritten scribble there, something to the effect that the report would not be required except

where the information under section 8 could not be obtained. Sibylle, do you have the other wording I have there as well?

**Ms Filion:** If we could just have a few moments so I can get something down on paper, it would be a separate subsection, which would be something like a (1.1), which would read, "A report under clause 18(1)(f) shall not be required unless the report is necessary to verify reports obtained under section 8 or to obtain information that cannot be obtained under section 8."

**Mrs O'Neill:** If I may clarify, I guess with Frank because he's the one who made the suggestion earlier, this would really only likely affect the big dealers. For the individual stores the information is available through the wholesalers.

**Mr Williams:** That's true.

**Mrs O'Neill:** That would certainly come a lot longer way in the amendment than the amendment that Mr O'Connor has just presented.

**Mr O'Connor:** That's what I was suggesting, that you deal with legal counsel to try to come up with an amendment that's going to address the concerns that you have.

**Mrs O'Neill:** That sounds a lot better.

**Mr O'Connor:** I'm just trying to work with my friendly colleagues here.

1620

**Mr Williams:** My information from Revenue, just to reiterate, is that basically we have no problem getting information on the individual retailers from wholesalers and distributors. It's Ontario corporation 123 that has 10 gas bars that comes and buys from a wholesaler-distributor and we don't know just where in Ontario those gas bars are located and how much tobacco is purchased and goes into each individual location. That's what we're concerned with.

**The Vice-Chair:** Any other speaker at this time?

**Mrs O'Neill:** I guess we'll have to wait for the amendment to the amendment, because it'll have to be voted on first. Correct?

**The Vice-Chair:** No, actually it will not be an amendment to the amendment. Your amendment stands because it's to strike out, as I understand it.

**Mrs O'Neill:** Okay, so we'll strike it out and then replace it with this?

**The Vice-Chair:** Replace it as an amendment.

**Mrs O'Neill:** All right. I think we can go for that.

**The Vice-Chair:** Do you wish to wait for the wording before you withdraw your motion?

**Mrs O'Neill:** I'm trusting that it's going to be as has been read. Is that correct?

**Mrs Caplan:** Very reasonable.

**Mrs O'Neill:** Okay, then let's go for withdrawing this and putting in something else.

**The Vice-Chair:** Mrs O'Neill withdraws her amendment to strike out clause 18(1)(f).

**Mrs O'Neill:** I think we have to have my amendment, don't we, and vote on it to get this out and put that in?

**Mrs Haslam:** Ms O'Neill's amendment is to withdraw (f)?

**Mrs O'Neill:** Yes.

**The Vice-Chair:** It can be withdrawn.

**Mrs Haslam:** So if we vote on hers and say yes to hers, then we can then put in—

**Mrs O'Neill:** Yes, that's what I'd like to do, is to get this out. I don't want to withdraw my amendment; I want to vote on my amendment to get this out of here and to get a new thing in.

**Mr O'Connor:** You may want to amend what we have here, so we may not want to remove it but amend it. Let's wait and see the amendment so your concerns can be addressed.

**Mrs O'Neill:** Yes, we'll have to wait and see it.

**The Vice-Chair:** The committee will then await the wording of the proposed amendment for a moment.

**Mr Sterling:** Mr Chair, on section 18, I don't see why we shouldn't perhaps discuss at this point in time, while we're waiting for the other amendment, clause 18(3)(b), which includes basically what I had proposed in section 5 of the act earlier this week, I guess it was yesterday. That was that clause (3)(b) provides the government with the opportunity to control packaging to the point of having plain packaging, as I read that particular amendment. I guess my question to the parliamentary assistant is, what plans or what kind of timetable can we expect the government to undertake in moving towards plain packaging in Ontario?

**Mr O'Connor:** I thank you for your question. As I had stated, the minister is at this present time consulting with the other provinces in an effort to develop a national strategy, to come forward with it so that we can approach it on a national basis. When we are dealing with all the jurisdictions across the country, sometimes this type of process can take a bit of time. I would hate to put a timetable to the minister at this point, though it's something that is a priority, there's no doubt.

I guess another part of this section would relate to Mr McGuinty's amendment around the numbers in the package size as well, to clarify where he had put down a minimum pack size. This deals with a number of areas, and I guess for some of the concerns that we heard from people around different ways that people have been able to circumvent the intentions of possibly the plain packaging by having an outer package and an inner package and the outer package being plain and the inner package actually then being a package similar to what we see today.

So there are a number of parts to this, but that's what we deal with in this section. I can't commit the minister to a time frame, though I know it's something that she wants to move forward with and has a great deal of concern on, as do many other Health ministers across the country.

**Mr Sterling:** Perhaps the parliamentary assistant, between now and when this matter is considered either in committee of the whole House or third reading back in the Legislature, would either speak to the Minister of Health or, if the Minister of Health is in fact going to be

carrying the bill at that stage of the game, forewarn her or give her notice that I'm going to be asking the same question at that point in time, that I'd like to get some kind of time line on this.

I think it's much fairer for all parties that people have an idea as to when Ontario is going to act in isolation, if that's necessary. I mean, it's nice to talk about consulting with all of the other ministries, but there are 10 provinces and two territories and there may be some disagreement among them as to when to act and when not to act. Therefore, I'd like to have some kind of idea. I don't think we're going to hold the minister to the day or to the month even, but I'd like to know whether this is a year project or it's a three-month project or it's a two-year project.

I believe that clause 18(3)(b) of this bill has more effect on kids taking up smoking than just about anything else in this bill and therefore I'd really like to get a time line. If you'd be good enough to notify the minister that I'm going to be asking that question and expecting some kind of serious response, I would appreciate it.

**Mr O'Connor:** I appreciate that and take that as notice and so duly will be recorded in Hansard. I at this point have before me, Mr Chair, a motion that I think will hopefully put to rest some of the concerns around this section that we have been debating for some period of time.

**The Vice-Chair:** Yes, Mr O'Connor. Would you proceed to read the proposed motion.

**Mr O'Connor:** I move that section 18 of the bill, as set out in the government motion, be amended by adding the following subsection:

"Exception

"(1.1) A regulation shall not be made under clause (1)(f) unless a report referred to in that clause is necessary in order to,

"(a) verify reports obtained under section 8; or

"(b) obtain information with respect to the sale of tobacco that cannot be obtained under section 8."

I hope that this can be seen as a friendly amendment under the constructive advice of my colleagues here in the wish to make this legislation as workable as we can and not place undue, strenuous burdens on the retailers in the province.

**Mrs O'Neill:** Mr Chairman, I would like to place my motion to remove clause (f). We would replace it with—

**Mrs Haslam:** No, this is an addition.

**Mr O'Connor:** This would be additional.

**Mrs O'Neill:** This is a much better (f) than what he's got in here now. Why can't we get rid of what's in here now?

**Mr O'Connor:** Because it refers to (f).

**Mrs Haslam:** It qualifies it.

**Mrs Caplan:** It qualifies (f).

**Mrs O'Neill:** Well, all right.

**Mr O'Connor:** What I have here is a qualifier, and I would hope that, Ms O'Neill, when you take a look at it—



**Mrs O'Neill:** It's hard to deal with something we don't have in front of us.

**Mr O'Connor:** The good intentions that you've presented to this committee I think are valid concerns and I think that this is a qualifier that will, I believe, be amenable to your concerns.

1630

**Mrs O'Neill:** Could we have a copy of that before we leave today, please?

**Mr O'Connor:** Yes.

**Mrs O'Neill:** I guess I will have to withdraw the amendment. I think I have achieved something for the small business people of the province.

**The Vice-Chair:** Ms O'Neill withdraws her amendment to section 18. Mr O'Connor, would you at this time present your amendment to your motion.

**Mr O'Connor:** I believe that I've read that in.

**The Vice-Chair:** You've read it, but it has not been moved.

**Mr O'Connor:** I move that section 18 of the bill, as set out in the government motion, be amended by adding the following subsection:

"Exception

"(1.1) A regulation shall not be made under clause (1)(f) unless a report referred to in that clause is necessary in order to,

"(a) verify reports obtained under section 8; or

"(b) obtain information with respect to the sale of tobacco that cannot be obtained under section 8."

**The Vice-Chair:** This is an amendment to the motion that you previously moved that's before the committee.

**Mr O'Connor:** That's right. It's to address the concerns by many of the committee members.

**The Vice-Chair:** Discussion on Mr O'Connor's amendment to his motion. Anyone wishing to speak to the amendment at this time? If not, the amendment to the motion has been read. All those in favour of the amendment, please indicate. Opposed? Carried.

Mr O'Connor's motion to amend section 18, as amended, is now before the committee. Did anyone wish to speak or are you ready to vote?

**Mr McGuinty:** I just want to speak very briefly in support of the regulatory authority given here to the government to deal with packaging, and in particular I want to make it clear that it is my understanding that we are hereby giving government all the authority it needs to regulate packaging in every way, shape or form, no ifs, ands or buts. I just want to put that on the record, and if any member of the committee is in disagreement with my statement, I'd ask that they speak now.

**Mr O'Connor:** Or for ever hold their peace.

**Mrs Caplan:** Our expectations of government moving on this expeditiously are very high. We all want to see plain packaging as quickly as possible.

**Mr O'Connor:** I guess given the light in the sense of what Mr McGuinty's presented, maybe we could have legal counsel respond.

**Mr Williams:** I just have one comment. I would take

exception to your butts. This is a tobacco bill.

**Mr McGuinty:** That's "b-u-t" for the purpose of the record.

**Mrs Caplan:** Good quip.

**The Vice-Chair:** Anyone else wish to speak to the amendment?

**Mr Sterling:** I'm happy to see that the government has made it clear in this bill that it is talking about plain packaging. My concern was that the previous bill was talking about health warnings alone in terms of notices on the package.

As I said previously, my concern was with the explanatory notes in Bill 119 under section 5 which, in my view, was sort of indicative of the kind of overall interpretation one might give section 5 of the bill, that they were talking about packaging in terms of health warnings and health warnings alone.

I'm very happy that they have incorporated into section 18 the kinds of issues which I raised in my amended amendment to section 5 yesterday, that the government will have control over the kind of lettering, the size of lettering, the type of lettering, the kind of colouring, whether it has to be all one colour, what kind of decorative elements they can use on it, if any, and that kind of thing, and the location of that print as well.

I'm very happy that they've included clause (b) of subsection 18(3) in this bill and I'm very supportive of it.

**Mrs O'Neill:** I wonder if I could ask the parliamentary assistant regarding the prioritization that's going to be given to the criteria and the establishment of the criteria. The last item we dealt with in committee before we went into clause-by-clause was a letter to the ministers, particularly the Minister of Labour, regarding workplace smoking regulations.

This is a very important section of the act. I think half the witnesses at least talked to us about it. I would hope that, in conjunction with the owners, occupiers and operators of this province, this part of the act would be given very strong prioritization. Something should be happening here, I would suggest, by early fall at the latest. I really do believe that I want to have some kind of statement from the parliamentary assistant to that effect, just to satisfy those people, because every single person in the province is going to be affected by this part of the act.

**Mr O'Connor:** I appreciate the challenges as put to me here. I think we ourselves have come together as a committee and put forward a very strong statement by writing directly to the minister suggesting that this happen in the very near future. I note that my copy of the letter we wrote to the minister appeared on my desk this morning. So as a committee and as a member of this committee, I think that very strong statement we all agree has been made and we had that presented and put forward. I think it's a concern that we do have.

I think there are actually equally important parts of this legislation that will deal with other issues, including workplace issues which we are yet to deal with, but I certainly do appreciate the opportunity to support Mrs O'Neill on that.

**Mrs O'Neill:** For the record, Mr O'Connor, you also

stated that education would be a very high component of the bill and there would be funds devoted to education to accompany Bill 119. I hope that is a priority of this government.

**Mr O'Connor:** In fact there were substantial amounts of money already spent in this fiscal year, gone out to public health communities throughout the province. As parliamentary assistant, I've had the opportunity to visit many different locations throughout the province and see some of the fine work, this public education you refer to that's necessary, to see some of those components come together. I agree with you it's a very important part of this as well.

**Mrs O'Neill:** Finally, Mr Chair, I place my request again for those programs that are in place and the moneys that have been set aside and hopefully are flowing to those tobacco growers who are trying to change their production, who are trying to find other ways to support their families. It's my third request.

This is the last day, but I still place the request and trust I will get that. I know that's not Mr O'Connor's area of responsibility, but surely this committee has a right to ask for that through our clerk, through yourself, to the minister responsible, who I believe is the Minister of Agriculture.

**Mrs Caplan:** I think we're ready to vote.

**The Vice-Chair:** We have Mr O'Connor's motion, as amended, which replaces section 18. All in favour of Mr O'Connor's motion as amended? Opposed? Carried.

**Mr McGuinty:** I just want to note for purposes of the record that this passed unanimously.

**The Vice-Chair:** It passed unanimously. That's correct.

There was a PC amendment to subsection 18(2).

**Mr Sterling:** I've withdrawn that. I'm not going to present that.

1640

**The Vice-Chair:** Section 19, a Liberal amendment. Mr McGuinty, do you wish to proceed at this time?

**Mr McGuinty:** Yes, Mr Chair. I'll begin with section 19.1 of the bill.

I move that the bill be amended by adding the following section:

"Report by chief medical officer of health

"19.1(1) On the first anniversary of the day this section comes into force and annually thereafter, the chief medical officer of health appointed under the Health Protection and Promotion Act shall present a report on this act to the Legislative Assembly.

"Contents of report

"(2) The report shall contain an assessment of the effectiveness of the act in reducing the use of tobacco in Ontario, an assessment of the enforcement of the act and the level of compliance with the act and recommendations, if any, for means of improving the effectiveness of the legislation, including amendments to this act."

**The Vice-Chair:** Thank you. Did you wish to comment?

**Mr McGuinty:** Yes. One of the recommendations that was made to us I think time and time again during the course of the committee hearings was that there should be some system for following up and for monitoring the performance of this bill. I'm sure we all have high hopes for it but I think there should be a system in place, as I say, which will allow us to measure its performance in a very real way.

The proposal that I put forward here is one that was made by a number of presenters, which would simply require that our chief medical officer of health, whom I would like to see play a more active role in promoting health in the province—I know he does, but I'd like to see that role given further profile—comes back to the House and, via a report, lets us know specifically what kinds of inroads we have been making, and perhaps more important, where we can improve the bill further.

Smoking, especially in so far as it relates to children in this province, has been a problem that has continued unabated for some time. I would like to think that this is not the last of our efforts directed particularly at preventing children from starting to smoke.

We had an interesting example here just recently when we had a coroner who had presided over a coroner's inquest, I think a couple of weeks ago, return to Queen's Park pursuant to a directive contained in the coroner's jury's recommendations that he follow up one year later to report on which of the recommendations had been followed through on by whoever was supposed to do so.

Again, it just called attention to the original problem which brought about the coroner's inquest in the first place and let the public know what kind of progress, if any, was made. That's why, for the very same reasons, I would submit that this kind of a provision will again cause us, as legislators, to focus on this problem and also give notice to the public as to what kinds of advances we've made and what remains to be done.

**The Vice-Chair:** Thank you. Mr Sterling.

**Mr Sterling:** I want to strongly support this motion by my Liberal colleagues. As you can see from the motions we've put forward we had a very similar motion, and I don't think they differ that much that it would require me to put my motion, so I'm not going to present that motion at this time.

I think one of the things the committee might want to do after this bill is passed would be to—if in fact this kind of amendment was accepted by the government; it's something which I think is extremely important in terms of accountability in our Legislature regardless of which government happens to be there.

What I would like to see if this kind of amendment does pass is that the committee call before the committee the chief medical officer of health and ask him or her what kind of method or what kind of reporting or assessment he or she would undertake in terms of carrying through this function.

I say that in terms of having sat on a committee with the freedom of information and privacy commissioner, because if you establish early on how in fact that assessment is going to take place and how the reporting func-



tion is going to take place you can save yourself a lot of money and anguish and time by setting up whatever systems you're going to set up to know how the information is going to be required to be spun out to the public.

If this committee, for instance, decides that it wants a certain kind of information and it's going to be collected in a certain manner, then everybody knows how to set up their computers, what kind of software will be needed, and that will be established early on in the game.

I think the idea of having a yearly review of this particular matter would be good. I would hope, if the section was passed, that some time in the spring after it was passed the medical officer of health would come in front of this committee and indicate to the committee how he was going to undertake this kind of reporting and that it would be clear what kind of data he would be collecting, where it would be coming from, so that everybody in the government, everybody in the private sector would know how this was going to be done, so that the collection of that information would be done in the least expensive way and the least bothersome way to all of the people who are required to report under this act.

**Mr O'Connor:** I really do appreciate this opportunity to speak on this amendment. I think the intention is terrific. I think that we, as members of this committee, really want to see this followed. I have a concern but point out that the chief medical officer of health of this province has taken this issue as probably his key, number one focus.

In second reading debate in the House I quoted Richard Schabas, the chief medical officer of health for the province, and stated that he felt that public health enemy number one was tobacco. His 1991 report to the province was completely dedicated to the issue of tobacco use, tobacco not being his only concern. He does file an annual report, and I think this medical officer of health has been quite diligent in filing these reports on an annual basis.

Committee members will recall that some of this information was presented to us when the chief medical officer of health for the province came to this committee, and he used some of the information in his subsequent report, 1992, and I believe in his report on the heart again mentioned tobacco-related concerns.

My only concern here is that we're going to compel him to annually report on this issue. I think it's something we all agree we need to track, we need to see where it's at. I think annual reporting to it might be a little bit onerous, and then having him reporting to the Legislature goes beyond what he has had mandated to him in the past. That could be a concern.

I think the chief medical officer of health, upon hearing this debate, is going to want to report. In fact maybe what we can do, I would suggest, is that this committee might even want to write to the chief medical officer of health of the province of Ontario, suggesting that he report on a very regular basis to the Legislature where we are headed in so far as compliance with the Tobacco Control Act is concerned, maybe suggestions on how we can improve the direction and where we're

going. I worry about our compelling him to report on an annual basis to us as a Legislature something that hasn't been compelled of him in the past. I worry that at some point in the future other issues may come up and we're compelling him to do something that would put him in time frames that might restrict his ability to react to whatever the most current public health concern is of the day.

I think the intention here is fine. I think that compelling him to report on an annual basis in itself does prove to be somewhat problematic, though. I think we've seen a commitment from the medical officer of health to keep this in the forefront as a very serious public health issue, and I don't think that by our not including this in the legislation we're going to see him all of a sudden not talk about this and speak out very loudly and vociferously on the concerns of this public health issue.

1650

**Mrs O'Neill:** Again, we're having the same situation we had earlier where the parliamentary assistant's interpreting what a person who now presently holds the office might do, or has done even. We're talking about an office, not a person who holds that office or is the officer at this moment.

This is one of the very few health bills—and there aren't a lot of health bills or bills that refer to health. There are certainly very few bills, period, that have unanimous consent, and this is going to have so. We know this is important. We know it affects 13,000 people minimal—and that's those who die; that's not those who are affected by all kinds of other medical problems—and yet we don't want to report on that annually?

I was reading today how drunk driving is now at a standstill as far as its decline. There is a hard core of people, a new study that proves it has reached and bottomed out, as they say. Are we going to let the same thing happen with the tobacco? We need to have an annual report on how we're doing. I'd like certainly to have the medical officer of health come forward with the newest and latest cessation proposals, things that can be done for young people, and make this a priority.

Every person in any position has to have priorities. Sometimes we're in a position to set some of those for the people who work for us, which happens to be some of the people we're talking about right now.

I feel very strongly that this would not be onerous. It sets a priority. It carries it through. It's on an annual basis. This report then goes out right across the province to all the other medical officers of health and is then distributed within the communities. It follows through with this bill being a priority for this province at this time and for ever thereafter.

**Mr Sterling:** I must say I'm disappointed by the parliamentary assistant's response to this. I think Ms O'Neill makes a good point. We're not talking about a person here; we're talking about an office. That office is the chief medical officer of health in Ontario.

The other part that's important here is that Mr O'Connor acknowledges that the medical officer of health has stated this is the number one problem. So why

wouldn't we want him to report on an annual basis to the Legislature as to how it was going? I think what we need to do, if this is the number one problem, is to continue to have a focus on this year after year after year. I might even go further than this. I think this is a fairly minimal requirement.

The only thing I would be concerned about is if the medical officer of health thought the resources that were required in order to do this were so great that it was pulling him off other things where he could use that money in a more productive manner to discourage more young people from taking up the habit, but I haven't heard that and therefore I assume that's not the case.

I want to say that I strongly support this and I think it's a mistake on the part of the government to not continue to have this focus on this number one problem, as the parliamentary assistant has said.

**Mr McGuinty:** Just to confirm, it may very well prove to be onerous in terms of the amount of work the chief medical officer's going to have to do to fulfil this, but doesn't this problem warrant that? If the parliamentary assistant has said it once, he's said it 150 times: 13,000 Ontarians die every year as a result of a smoking-related illness. He has said that smoking is the single greatest preventable cause of illness in this province.

**Mr O'Connor:** According to the chief medical officer of health.

**Mr McGuinty:** I don't have any qualms whatsoever about placing this responsibility on our chief medical officer, and I think it has to be annually. We should have an update annually so that we can measure in a very real way what kind of inroads we're making, and if we're not, what do we do to take corrective measures?

**Mr O'Connor:** I appreciate the intention here; I think the intention is fine. In fact what we'd like to monitor here through this would be the effectiveness in the intent of the legislation, which is the young people here. I suppose that could even have been mentioned in his amendment.

I think the key here is that we do have and currently do fund the Ontario tobacco research unit through the province of Ontario. They will monitor and they will be watching to make sure and evaluate—they will be evaluating—the effectiveness of the entire strategy that we have before us. They will not only be evaluating the legislation but the communications and, of course, as Ms O'Neill raised, the importance of the community action and what's happening there and the support from the communities.

We actually have a unit in the province of Ontario that is doing just that, and we have a committed chief medical officer of health who has been mentioning this in his report and in fact in 1991, as I stated, dealt with this through his entire report. My concern is that we're going to be causing duplication and added government that may be not necessary.

I think we all have some very serious concerns here and I know we have a unit, the tobacco research unit, that is getting funding through the centre for health promotion at the University of Toronto, for example. They are

getting funding and they will monitor the effectiveness of this legislation, of the action in the community and the supports out there. We're going to have that reporting. It's not by the chief medical officer of health, so I have some difficulty with that, but I think the intention that you have here is important.

I think we're reaching the intention already, currently. We do have a way of reaching that through what we have in process already. I certainly wouldn't want to take away from what we've been receiving at this point from the chief medical officer of health. He has been reporting on an annual basis and reporting on this issue, but to compel him through this legislation—I have some difficulty.

**Mrs Caplan:** The parliamentary assistant has convinced me that in fact the amendment Mr Dalton has placed is a good one. You've just told us that there is a unit in place that can do the work and present the report to the medical officer of health who can then present the report to the Legislature. It's there, it's done, it's not going to require any additional work and you've convinced me that you should be supporting Mr Dalton's and the Liberal amendment.

**The Vice-Chair:** That's Mr Dalton as in McGuinty.

**Mrs Caplan:** I'm sorry.

**Mr O'Connor:** Mr Dalton, Mr McGuinty.

**Mrs Caplan:** I'm sorry.

**The Vice-Chair:** That's all right.

**Mrs Caplan:** Right. My colleague Dalton.

**The Vice-Chair:** I knew who you were talking about.

**Mr McGuinty:** I was the only rookie, you see.

**Mrs Caplan:** It's late in the day.

**Mr O'Connor:** Mr Chair, I do have further motions I'd like to move. The difficulty we—

**Mrs Caplan:** Think about this: A legislative requirement for accountability makes sense. I can understand your concern about its being onerous, except that you've now told us there is an institute that you are funding to do the research and to do the work. That work can be made available to the medical officer of health, who can then report to the Legislature. That accountability is good and it should be supported.

**Mr McGuinty:** It's trite, but I'll repeat it. This is an important issue and we, as legislators, get caught up in all different kinds of things during the course of the year with our various responsibilities and from time to time people have to hit us over the head to remind us how important some particular issues are. They may have to draw our attention to this issue time and time again, and that is my intention in having somebody come forward and report to the Legislature on this problem and the inroads that we have made and the further steps we can take.

**Mr O'Connor:** I appreciate some of the concerns as raised. I appreciate Mr McGuinty's suggestion that somebody should be doing this reporting, that we hear some reports from somebody about this issue. I would suggest that this committee, given that it's not the chief medical officer of health's unit that is preparing the information, and perhaps he may have some difficulty in



signing his name to someone else's report, that perhaps his unit—I would suggest, so that we can comply with Mr McGuinty's wishes here, that for this unit that is getting funded by the province of Ontario, we get a copy of that report annually. I think every member of the Legislature should get a report from them.

1700

We're not compelling the chief medical officer of health. Let's get on the mailing list for some of the work that's being done in the province right now, and maybe that's an approach that we can do. I have difficulty compelling the chief medical officer of health here. I know that he may and we may—you have difficulty sometimes signing your name to someone else's work. That being the case, let's get the work that's being done and have that presented to us.

Mr McGuinty suggest that somebody should be reporting to us. That's a reasonable account and perhaps we should get somebody to do it. Maybe we have that avenue open to us. As was suggested by Ms O'Neill on the workplace issue, we wrote a letter together as a committee, and maybe we should do that to this unit and get that report, request that on an annual basis.

**Mr Sterling:** I'd like to vote on this as soon as possible.

**The Vice-Chair:** Like right now? Any other comments?

**Mr McGuinty:** Do I take it the parliamentary assistant's position then is that he would prefer that I substitute for "chief medical officer of health" in my amendment "this committee"?

**Mr O'Connor:** Mr McGuinty, you suggested that somebody should be doing the reporting. I'm saying that work is being done currently, and that as a committee we should, yes, get that information, because as members of the Legislature we're concerned about that.

We should then get the information that is being put together, whatever mailing list we need to get on so that we can get that information. It might even be on a weekly basis if possible. We could probably go to all the many units across the province that are working on this issue and have updates from right across the province. It would be probably even more far-reaching than what we're getting from your wishing to compel the chief medical officer of health.

**Mr McGuinty:** If the government is really sincere in its intention to address the tobacco problem in this province, then I think an essential component of any such strategy has to be that we compel somebody to report on our progress. It's not a matter of leaving it up to somebody's discretion or some committee down the road asking for something. We should be compelling somebody to report to us regularly. I think if you're sincere and you're interested and this just isn't a flash in the pan, then you will compel somebody to do so. If it's not the chief medical officer of health, fine. Just give me an alternative and let's put somebody else in there.

**Mrs O'Neill:** The more that Mr O'Connor speaks, the muddier the water seems to get, because he is now talking about several bodies and he is not talking about

presenting a report on this act. This act is different. This act has several components to it. Whether it affects the retail industry, whether it affects the schools, whether it affects the laundry, all of these things are very different and I think that it should be directed to this act. I want a recorded vote on this amendment presented by my colleague.

**Mr O'Connor:** I guess the key here is that in dealing with all of what we've had discussed here, we've heard discussion that the communication is going to be so important, the grants to the community, so that the grants going to these communities that are going to develop cessation programs, which is part of the entire strategy, which doesn't limit us then to just this act—that we monitor the strategy, that we are going in the province far beyond what is included in this act, and that we have that.

We're doing that now through the Ontario tobacco research unit, which is at the centre for health promotion through the University of Toronto. We have that ability to deal with not only the confines of the legislation but also the entire communication, the work in the community, and we can go beyond that.

I think what needs to be monitored here is not just the very limited scope of this very important legislation but the entire strategy, which includes all the community work as well, as has been pointed out on many occasions through these hearings.

I guess we're prepared to vote.

**Mrs O'Neill:** A recorded vote.

**The Vice-Chair:** Thank you. Anyone else? You've heard Mr McGuinty's amendment. All in favour of Mr McGuinty's amendment at this time?

**Ayes**

Caplan, McGuinty, O'Neill (Ottawa-Rideau), Sterling.

**The Vice-Chair:** Opposed?

**Nays**

Abel, Carter, Frankford, Haslam, O'Connor.

**The Vice-Chair:** That is defeated.

Government amendment to section 19.2.

**Mr O'Connor:** I move that the bill be amended by adding the following section:

"19.2(1) Paragraph 34 of section 210 of the Municipal Act is repealed.

"(2) The Municipal Act is amended by adding the following section:

"Definitions

"213(1) In this section,

"'public transit vehicle' includes a school bus and a passenger vehicle used for hire;

"'workplace' includes a public transit vehicle.

"Bylaw, smoking in public places and workplaces

"(2) The council of a local municipality may pass a bylaw regulating the smoking of tobacco in public places and workplaces within the municipality and designating public places or workplaces or classes or parts of such places as places in which smoking tobacco or holding

lighted tobacco is prohibited.

"Same

"(3) A bylaw made under subsection (2) may,

"(a) define 'public place' for the purposes of the bylaw;

"(b) require a person who owns or occupies a place designated in the bylaw to post signs referring to the prohibition or to such other information relating to smoking as is required by the bylaw;

"(c) prescribe the form and content of signs referred to in clause (b) and the place and manner in which the signs shall be posted;

"(d) permit persons who own or occupy a place designated in the bylaw to set aside an area that meets criteria prescribed by the bylaw for smoking within the place;

"(e) prescribe the criteria applicable to smoking areas in clause (d), including the standards for the ventilation of such areas;

"(f) require areas set aside for smoking in places designated by the bylaw to be identified as an area where smoking is permitted; and

"(g) require the employer of a workplace or the owner or occupier of a public place to ensure compliance with the bylaw.

"Public places

"(4) Despite any definition of 'public place' contained in a bylaw made under subsection (2), no bylaw made under subsection (2) shall apply to a street, road or highway or a part thereof.

"Inspectors

"(5) A local municipality may appoint inspectors for the purpose of a bylaw made by the municipality under subsection (2).

"Entrance without warrant

"(6) An inspector may, at any reasonable time, enter any public place or workplace designated by a bylaw under subsection (2) for the purpose of determining whether there is compliance with the bylaw.

"Dwelling

"(7) Despite subsection (6), an inspector shall not exercise a power to enter a place, or a part of a place, that is used as a dwelling unless,

"(a) the occupier of the dwelling consents to the entry, having first been informed by the inspector of his or her right to refuse consent; or

"(b) if the occupier refuses to consent, the power to enter is exercised under the authority of a warrant issued under section 158 of the Provincial Offences Act.

"Powers of inspector

"(8) An inspector may make such examinations, investigations and inquiries as are necessary to determine whether there is compliance with a bylaw made under subsection (2).

"Obstruction

"(9) No person shall obstruct an inspector carrying out an inspection under this section.

"Warrant

"(10) A judge or justice of the peace may, upon application by an inspector appointed under subsection (5), issue a warrant authorizing the inspector to enter, examine, investigate or make inquiries with respect to a public place or workplace if the judge or justice of the peace is satisfied by evidence under oath that,

"(a) the entry, examination, investigation or any inquiry is reasonably necessary for the purposes of determining whether there is compliance with a bylaw made under subsection (2); and

"(b) the inspector has been prevented or is likely to be prevented from exercising any of his or her powers under this section or the inspector has been obstructed.

"Expiry of warrant

"(11) A warrant shall name the date on which it expires.

"Execution of warrant

"(12) A warrant may specify the days and hours during which it may be executed and if there is no such specification in the warrant, the warrant shall be executed between 6 am and 9 pm on any day of the week.

"Use of force

"(13) The inspector may use such force as is reasonably necessary to execute the warrant and call on police officers to assist in the execution of the warrant.

"Application to upper-tier municipalities

"(14) A county, district, regional or metropolitan municipality or the county of Oxford may exercise the powers under this section if a majority of the councils of the area or local municipalities within those municipalities approve the exercise of such powers.

"Conflict with other bylaws

"(15) A bylaw made by a county, district, regional or metropolitan municipality or the county of Oxford under subsection (14) supersedes any bylaws respecting smoking made under this section by the area or local municipalities within those municipalities.

"Repeal of bylaw

"(16) A bylaw made under subsection (14) is repealed if a majority of the area municipalities rescind their approval.

"Offence

"(17) Any person who contravenes subsection (9) is guilty of an offence.

"Crown bound

"(18) This section binds the crown.

"Conflict with other legislation

"(19) In the event of a conflict between a provision in a bylaw made under this section and a provision of any act or regulation, the provision that is the most restrictive of smoking prevails."

Just in commenting to this, we heard from a huge number of people that it was time that we enabled some municipalities to deal with this issue in a reasonable and responsible fashion locally, and I think this amendment respects the wishes of those many people who came to



this committee and made presentations to us.

**Mrs O'Neill:** I just have a couple of questions of clarification. If I may ask, on subsection 213(1), "public transit vehicle" includes a school bus and a passenger vehicle used for hire," that I presume includes taxis.

**Mr O'Connor:** Yes.

**Mrs O'Neill:** Taxis can, however, still be designated as smoking and non-smoking taxis in a municipality but must be labelled as such. Is that correct?

**Mr O'Connor:** Yes, and by the municipality.

**Mrs O'Neill:** All right. So there still can be taxis in which smoking is permitted but they would have to be labelled as such.

**Mr O'Connor:** Yes. They would be designated that by the municipality.

**Mrs O'Neill:** All right. The next question is regarding public places in subsection (4), "Despite any definition of 'public place' contained in a bylaw made under subsection (2), no bylaw made under subsection (2) shall apply to a street, road or highway."

Are we then suggesting in this that any of the designated places in our section 9 of the act, the street, road or highway in front of them, cannot be smoke-free? In other words, the same thing that's going on right now on Wellesley Street in front of that school can continue to go on, in that the students stand on the sidewalk right outside the fence of the school and that will continue. Is that correct?

**Mr O'Connor:** I guess that's a public place that would be very problematic in trying to—

**Mrs O'Neill:** So in each one of the designated spots in section 9, no matter which, the person can just step outside and stand on the sidewalk and there's no problem.

**Mr O'Connor:** It depends whether the sidewalk is on the property or off the property of the designated spot. If the sidewalk is a public place, is part of a right of way for people, then—

**Mrs O'Neill:** All right, I just want to clarify that. I think it's particularly crucial in reference to schools and nurseries and perhaps some of these others, but certainly those where there are large numbers of people on a daily basis, many of whom may want to gather to smoke.

**Mr McGuinty:** I just want to speak briefly in favour of this amendment. We did, as the parliamentary assistant pointed out, hear from a number of presenters of the need to grant the necessary lawmaking authority to municipalities so that they could address the smoking-related problems within their community and at a pace that they felt was in tune with the thinking of the people who live there. It's certainly something that my party and our leader have felt was a way of enabling people, giving people the powers to solve their problems locally. I think it's a very good amendment and I intend to support it.

**The Vice-Chair:** Any other speaker? We have Mr O'Connor's motion before us to amend subsection 19(2). All in favour of that amendment? Unanimous.

A Liberal amendment to subsections 19.2 and 19.3. Mr McGuinty, is that going forward at this time?

**Mr McGuinty:** Yes, it is.

I move that the bill be amended by adding the following sections:

"Smoking cessation programs

"19.2 The Minister of Health shall assist boards within the meaning of the Education Act that administer secondary schools in establishing in those schools a program to encourage secondary school students who smoke tobacco to cease smoking.

"Same, OHIP coverage

"19.3 The Minister of Health may require the Ontario health insurance plan to compensate,

"(a) a board within the meaning of the Education Act for the cost of establishing a program under section 19.2; and

"(b) any person for the cost of enrolling and attending a program approved by the Minister of Health intended to encourage the cessation of smoking whether or not the program is established by a divisional board under section 19.2."

My intention here is to encourage the Minister of Health to assist school boards in establishing programs which will help students who are smoking to stop smoking. One of the interesting things we heard in Sudbury from Big Tom, as he called himself to me—I forget his last name, but he was the principal of the school up there—was that he found it rather perverse that the board was offering a smoking cessation program to adults, to the teachers, but the kids who were hooked on cigarettes were being left behind and ignored.

He'd begun a program there in which he involved students who were smokers and he'd found, from his own personal experience, that the best way to get at kids who were smoking was through other kids themselves rather than through adults and advertising and the preaching approach. That's what section 19.2 talks about.

Section 19.3 simply is permissive and says that the Minister of Health may want to compensate or to assist financially a board that wants to set up a program that will involve smoking cessation, or the minister may pay for, through OHIP, those programs in which any individual in the province may enrol in order to stop smoking. I think a good financial argument could be made to the effect that it is cheaper for us to pay for someone to unhook them from smoking than it is to pay for the long-term costs associated with treating their various illnesses in whatever form they happen to manifest themselves.

1720

**Mrs O'Neill:** I strongly support this amendment presented by my colleague. The schools that came before us for the most part had not engaged in cessation programs. We did hear in Sudbury of the—and I think we were all deeply impressed by the presentation from Lively, Ontario, where students and principal—and actually they brought their health and safety member to the presentation. They considered it very seriously, seriously enough that they offered as a credit program, for 10 weeks, the cessation program, and there were people there, students, who testified that it had certainly been a benefit.

This is an incentive to boards. It also helps boards that are really struggling now with the choices they have to make. It is a health matter; we've heard that over and over again. If we're going to put any teeth into this bill, if we're going to help people where they spend most of their time—young people spend most of their time at school in one way or another, and I think data support that—I really do feel that this is a very positive part and addition to the act that would give boards some direction and encouragement to help the young people they wish to serve.

**Mr O'Connor:** I appreciate the intent here. I think that it could likely be ruled out of order because we're compelling some costs to be incurred here.

I'd like to point out the fact that the intent in general here is quite well meaning. Right now, health units have a responsibility to ensure that smoking cessation programs are available. I think that after hearing from people like the folks from Lively, there's going to be a need for some programs, because there are young people in schools who have this addiction. That's no surprise to us.

At the same time, they've been able to deal with it locally, not being mandated to, but having done so. The difficulty here is that we have somebody who's mandated to have this program right now; the health units are there. Their responsibility is to ensure that cessation programs are there. They're responsible for the delivery of these programs. The school boards themselves aren't responsible at this point for the delivery of these programs.

In fact there are many different agencies out there right now that currently get moneys from the Ministry of Health for cessation programs, like the Lung Association in some communities, the cancer society in some communities and people with the heart and stroke foundation, for example. There are many different groups out there in the communities that have programs, and I think what you're suggesting here is that they be encouraged maybe to go into the schools and offer these programs.

I think that the problem here is that we're compelling this and we're ordering the ministry to spend the money on this. The ministry is spending the money; it's currently happening. I certainly support the intention you have here and I support all of the people out there in the province right now, all the many different agencies that are all part of the overall strategy, that have been involved in delivering cessation programs throughout the province currently.

**Mr Robert Frankford (Scarborough East):** I too very much appreciate the intent of the member's proposal here, but particularly on the OHIP section I have some reservations and real doubts whether it actually can stand. OHIP, I think, comes under the Health Insurance Act and it is essentially a way of paying for practitioners on a fee-for-service basis.

I think that we have to be getting away from that and I feel that the approaches which occur right now are in relation to public health and other ways in which the Ministry of Health allocates funds. So I really question both whether it's possible and whether it's desirable to be using OHIP as the vehicle for this.

**Mr McGuinty:** My intention is, first of all, to recognize that the smoking cessation programs we have now for our kids aren't working. Number two, if I'm a teenager and I smoke, I'm not going to attend a program after school. I've got better things to do with my time.

Where you do have me captive is in my school. I'm going to school. If we're going to deal with kids who are smoking, we've got to go where we find the kids, and that's in the classroom. I think, given the nature of this problem and its extent, that it's quite appropriate for us to implement smoking cessation programs in the school during school hours. This opens that possibility up.

There's no obligation placed here on the Minister of Health to compensate. Section 19.2 says "shall assist." That assistance can be via information and whatever way possible that the Minister of Health may feel appropriate so that we're not tying his or her hands. But, again, it's just to get at the kids where they are, and that's in the classroom, because they are not going to attend extracurricular smoking cessation programs. It's just not in their nature.

**Mr O'Connor:** I appreciate the intent here. I wish that maybe some other arguments could have been placed that convinced me, but I think that there are a lot of good cessation programs going out there and I don't think the member intended to suggest that there aren't some good ones out there. But I appreciate his intent here.

**Mrs O'Neill:** A recorded vote, Mr Chairman, please.

**The Vice-Chair:** We will now have a recorded vote—

**Mrs O'Neill:** And I'd like to have the two sections broken, 19.2 and 19.3.

**The Vice-Chair:** —on Mr McGuinty's motion to, first of all, amend section 19.2. All in favour of Mr McGuinty's motion on section 19.2?

**Ayes**

Caplan, McGuinty, O'Neill (Ottawa-Rideau).

**The Vice-Chair:** Opposed?

**Nays**

Abel, Carter, Frankford, Haslam, O'Connor, Rizzo.

**The Vice-Chair:** Amendment to section 19.2 lost.

Mr McGuinty's motion regarding amendment to section 19.3: All in favour?

**Ayes**

Caplan, McGuinty, O'Neill (Ottawa-Rideau).

**The Vice-Chair:** Opposed?

**Nays**

Abel, Carter, Frankford, Haslam, O'Connor, Rizzo.

**The Vice-Chair:** Motion lost.

Section 19: All in favour? Opposed? It's carried unanimously.

On to section 20, and there is a government motion to amend.

**Mrs Haslam:** Mr Chair, I know nobody wants to hear this at 5:30 at night, but what happened to a particular motion that was—

**The Vice-Chair:** We'll come back to it. It was stood down. There's only one amendment that was stood down.



**Mrs Haslam:** Yes, I just didn't see it and I wasn't sure whether we—

**The Vice-Chair:** I thought we'd deal with it at that point.

**Mrs Haslam:** That's fine.

**The Vice-Chair:** Thank you for reminding me.

**Mr O'Connor:** I move that subsection 20(4) of the Human Rights Code, as set out in section 20 of the bill, be amended by striking out "giving" in the sixth line and substituting "supplying."

I think this is a technical amendment and I hope that we have support.

**The Vice-Chair:** You've heard Mr O'Connor's amendment. All in favour? Opposed? Carried. That's carried unanimously.

Section 20, as amended: All in favour? Carried unanimously.

Now back to the Liberal amendment that was stood down, and that's an amendment to section 9, paragraph 8.1. It was stood down earlier today.

**Mr McGuinty:** That particular amendment proposes that we ban smoking in doctors' offices. You wouldn't think that would be cause for much concern. Nevertheless, I didn't have time to properly consult and I don't feel it would be appropriate to go ahead with it at this stage, although hopefully in the future we'll be able to reconsider that. So I'm withdrawing it.

**The Vice-Chair:** Withdrawn. Thank you.

**Mrs Haslam:** Wouldn't that be covered under paragraph 13, another class, if it's so desired at a later date?

**The Vice-Chair:** All in favour of section 9, as amended? Carried unanimously.

Section 21: All in favour? Carried.

Section 22: All in favour? Carried.

Section 23: All in favour? Carried.

Shall section 24, short title, carry? Carried.

Shall the long title of the bill carry?

**Mrs Haslam:** No, short title.

**The Vice-Chair:** We did short title just then. The short title is the Tobacco Control Act or something, and now we're to the long title. Shall the long title of Bill 119 carry? Carried.

Shall Bill 119, as amended, carry? All in favour?

**Mrs Caplan:** Recorded vote.

**The Vice-Chair:** All in favour of Bill 119, as amended? Carried.

**Mr O'Connor:** Request for a recorded vote here.

**The Vice-Chair:** All in favour?

**Ayes**

Abel, Caplan, Carter, Frankford, Haslam, McGuinty, O'Connor, O'Neill (Ottawa-Rideau), Rizzo.

**The Vice-Chair:** Opposed? None. And I don't get to vote at this time either.

**Mrs Caplan:** If you could vote, you would vote.

**Mr O'Connor:** If you could vote, you would support it.

**The Vice-Chair:** Shall I report Bill 119, as amended, to the House?

**Mr O'Connor:** Please do.

**The Vice-Chair:** All in favour? Carried.

**Mr O'Connor:** Before we wrap up this session, I would really like to extend my appreciation to the able work that we've had with Brenda Mitchell as she's travelled through the province with us, Frank Williams, legal counsel, and all the people in the health promotions branch who have worked with us.

We also appreciate the support and ongoing support we have received by all of the many people who have followed this legislation through this process. Thanks to OCAT, the Ontario Campaign for Action on Tobacco, who I think have been at just about every hearing we've had, no matter where in the province we've been, and I appreciate the unanimous support we've received with this bill for the most part.

**The Vice-Chair:** The meeting is adjourned.

The committee adjourned at 1733.

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## STANDING COMMITTEE ON SOCIAL DEVELOPMENT

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Owens, Stephen (Scarborough Centre ND)

\*Rizzo, Tony (Oakwood ND)

\*Wilson, Jim (Simcoe West/-Ouest PC)

*\*In attendance / présents*

### **Substitutions present / Membres remplaçants présents:**

Abel, Donald (Wentworth North/-Nord ND) for Mr Martin

Caplan, Elinor (Oriole L) for Mr Beer

Frankford, Robert (Scarborough East/-Est ND) for Mr Owens

Haslam, Karen (Perth ND) for Mr Hope

Perruzza, Anthony (Downsview ND) for Mr Rizzo

Sterling, Norman W. (Carleton PC) for Mrs Cunningham

### **Also taking part / Autres participants et participantes:**

Ministry of Health:

O'Connor, Larry, parliamentary assistant to the minister

Williams, Frank, legal counsel

**Clerk / Greffier:** Arnott, Doug

**Staff / Personnel:** Filion, Sibylle, legislative counsel



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Third Session, 35th Parliament

Assemblée législative  
de l'Ontario

Troisième session, 35<sup>e</sup> législature

**Official Report  
of Debates  
(Hansard)**

Monday 11 April 1994

**Standing committee on  
social development**

Dialysis treatment services

Chair: Charles Beer  
Clerk: Doug Arnott



**Journal  
des débats  
(Hansard)**

Lundi 11 avril 1994

**Comité permanent des  
affaires sociales**

Services de traitement par dialyse

Président : Charles Beer  
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## LEGISLATIVE ASSEMBLY OF ONTARIO

## ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON  
SOCIAL DEVELOPMENTCOMITÉ PERMANENT DES  
AFFAIRES SOCIALES

Monday 11 April 1994

Lundi 11 avril 1994

The committee met at 1531 in room 151.

## DIALYSIS TREATMENT SERVICES

Consideration of a matter designated pursuant to standing order 125 relating to dialysis treatment services.

**The Chair (Mr Charles Beer):** Good afternoon, ladies and gentlemen. Welcome to this meeting of the standing committee on social development. We are here today under standing order 125 regarding a designated matter, which in this case refers to dialysis treatment services. The direction the committee has been given is the following:

"That the committee meet for a period of 12 hours to review the commitment and level of priority that the Ontario government is placing upon dialysis treatment services in the province of Ontario in light of the growing crisis that is overwhelming dialysis patient care in the province."

This standing order 125 was moved by Mr Wilson and I would first ask Mr Wilson for any opening comments.

**Mr Jim Wilson (Simcoe West):** Thank you very much, Mr Chairman, and thank you, Minister, for attending. The need, obviously, for haemodialysis treatments in this province has for some time now been at a crisis level. I want to begin, with the committee's indulgence, by reading a letter that was sent to the minister, the Honourable Ruth Grier, dated January 16 of this year, from Dr Janet M. Roscoe, who's the chairperson of the Toronto Dialysis Committee, and it was cosigned by one of our presenters, in fact the first presenter today, Dr David Mendelssohn, who's vice-chairperson of the Toronto Dialysis Committee, because I think it outlines the situation currently in the province. It says:

"Dear Minister:

"You have received many letters attesting to the crisis in availability in dialysis facilities. This situation has now become even more catastrophic. An emergency dialysis roster was established approximately one year ago to accept emergent dialysis patients in an equitable way into existing dialysis programs. This system has been breaking down since Christmas because of the serious overcrowding in the existing units, as well as a lack of ICU beds. In the last three weeks there have been several near tragedies, the details of which I will be pleased to share with you if necessary. All programs are now saturated to a dangerous level. This is not a time for politics, putdowns or procrastination. It is imperative that the Ministry of Health respond with an immediate short-term solution. The opening of the Sussex Centre in March is both too late and inadequate to address the problem.

"The Toronto Dialysis Committee suggests that the most 'doable' short-term response is to:

"(1) Immediately expand (with full funding) the haemodialysis program at the Sunnybrook hospital to 15 stations working three shifts per day, six days per week.

"(2) Immediately expand the chronic care/rehabilitation dialysis program at Riverdale Hospital to six haemodialysis stations and six CAPD patients." CAPD is continuous ambulatory peritoneal dialysis.

"(3) Immediately provide funding to each existing home dialysis program to expand its program by at least 10% capacity.

"(4) Immediately provide nursing salaries for haemodialysis nurses to allow the establishment of long-needed satellite units in Alliston and Collingwood.

"Even these solutions will not be possible to execute without a time lag in the case of haemodialysis of at least two months. Home CAPD in most cases will be able to expand more quickly but will not be suitable for all patients and of course cannot be used in acute cases. Toronto nephrologists anticipate that patients needing dialysis in the next week may require transfer to other centres such as Kingston. Of course patients who are in extremely critical condition may die before such transfer can be accomplished. We will document all cases requiring transfer or who die as a result of the shortage of facilities (which have been brought to your attention on many previous occasions).

"Toronto nephrologists are aware of the pressing economic problems facing the government. We are very willing to participate in a planning process looking at options for future delivery of care which might reduce the cost per case of renal failure to the government. This however is a process which will require considerable time and cannot address the urgent current needs. Nevertheless we realize the government does have some funds and must prioritize them."

In addition to this letter, which I think quite well sets out the situation in the province, and Dr David Mendelssohn may want to update us on the situation, the House debated this issue and on December 9 passed a resolution standing in my name, calling upon the government to establish haemodialysis satellites in Collingwood and Alliston, or what's now termed the town of New Tecumseth.

Very briefly, one of the issues that's been very difficult to explain in 15 seconds or less on news clips about this issue is the current response of the government. Certainly, Minister, your response to my questions in the

House has been, "Yes, we see it as a serious situation and we're trying to do something about it," and the response given by government members in the Legislature on December 9 when debating my resolution also went along the lines that the government has launched a central Ontario or central-east dialysis study.

I just want to say for the record that you announced the funding of \$100,000 for that study in October and November of last year and we were told at that time that the study would take six months. The last time I asked you a question in the House, some two weeks ago, that very day was going to be the first full-fledged meeting of that study committee. So the study that was supposed to be done by now is just getting started and I'll be interested to hear your comments with respect to that.

Secondly, the response outside of Metropolitan Toronto, in particular of my area in Simcoe county, and it's been from the Toronto hospitals, where our patients are attached, has been that if you are serious enough and can no longer drive the great distances to either Toronto or Orillia, then you can get a haemodialysis machine in your home. Part of my resolution dealt with the economics and what I think is a commonsense solution to the haemodialysis crisis in this province. That is to establish dialysis satellites, because currently, for example, members should know that we have three machines in the Alliston or New Tecumseth area serving only three patients, yet as far as we can tell, we're up to about a dozen additional patients in that area who continue to have to drive.

It's very, very difficult to explain to people that while there are three machines in town, only three people can use those machines in their homes. The commonsense question I'm asked is: "How come I can't use my neighbour's machine? Why don't we put it in a central location and share the machine? Why do I have to continue?"—particularly during the wintertime, and you'll hear from patients this week who have to drive, often under treacherous road conditions, to Toronto, about what this is doing to their quality of life. In fact, you will hear that they have no quality of life, that many patients, on the days they don't have to travel to Toronto, spend those days staring out the front windows of their houses, wondering if the weather's going to be good enough, if they can get to Toronto. Members have to know that you have to have haemodialysis. There is no option. Our constituents have to drive here three days a week, regardless of weather conditions, or they die. There is no option.

Secondly, it's the exact same situation in Collingwood, where there are three machines in town; there are two in Collingwood and one in Thornbury, which is near Collingwood, or actually between Collingwood and Thornbury in the rural area. Again, particularly in Collingwood—I have one patient by the name of Mr Mackenzie. In fact, he and his brother both are dialysis patients. They literally live within blocks of one of those machines and they asked me, "Why can't I use Mr Udall's machine?" and Mr Udall says: "Why can't they use my machine? I've got one in my home. Why can't it be centrally located so that all the patients in town can

use that machine?" Minister, I'd be very interested in your responses to those very specific situations.

The motion before us now has been put in a more general sense so that we can examine the dialysis crisis across the province, to give all members of this committee and indeed all members of the Legislature the opportunity to bring forward the situations in their ridings.

#### 1540

Just very briefly, I don't want and didn't want, at the beginning of this process, to blame this government or to blame governments, but it has become an issue that is starting to be partisan because of what I perceive and what patients perceive and I think as nephrologists perceive—certainly Dr Mendelsohn and Dr Roscoe have stated there's a lot of foot-dragging going on and there doesn't seem to have been a response really at all from the government.

The government will claim that it expanded Orillia in Simcoe county. That filled up just as soon as it was expanded. When that was done, although it was done with the agreement of the district health council, people must have had their heads in the sand if they expected patients in Alliston to drive to Orillia, which is farther than driving to Wellesley Hospital in Toronto. In fact, the roads are better plowed in the wintertime down to Wellesley Hospital than they are to Orillia. So the whole situation the way it stands now defies common sense.

We've tried not to make it a political issue, but upon hearing that the study committee had only just begun its studying of the issue, I and patients became very discouraged.

I will leave it at that and allow the minister to respond and to make her comments.

**The Chair:** Minister, on behalf of the committee, welcome to the committee. We're very pleased that you were able to make some time to be with us today. With that, I'll let you make your opening comments.

#### MINISTRY OF HEALTH

**Hon Ruth Grier (Minister of Health):** I'm very glad that the committee is holding hearings into what is certainly for the ministry a top priority. I'm delighted to have the opportunity to come and make some opening comments.

My two parliamentary assistants, Mr Wessinger and Mr O'Connor, are also here and will be part of the committee. In addition, from the ministry Mr Donald Walker and Miss Monita O'Connor are here and will be here throughout the hearings. So I suspect you will get into the kind of specific questions Mr Wilson has posed with respect to discussion and dialogue as the hearings proceed.

What I thought I would like to do is to make some general comments and provide the committee with some background as to the actions the ministry had in fact taken in recent years, because providing services for people with kidney disease poses both a tremendous challenge to the health care system and I think an opportunity to look at how we can expand services, as well as make them more appropriately placed for people in the province because we know that travelling long



distances, as has traditionally been the response to this problem, is not what the people and the patients most prefer.

While dialysis treatment meets some of the challenges that are out there, we recognize and know that there is a tremendous need for organ donations, as well as for home care and family support services as well as greater emphasis on prevention through our treatment and acknowledgement of the problem caused by diabetes.

The latest figures show that there are over 5,600 men and women in Ontario with end-stage renal disease. Almost half of them are doing well with a kidney transplant, about one third are getting haemodialysis in hospital or at an outpatient facility and the rest are on peritoneal dialysis.

The number of end-stage kidney disease patients continues to climb by about 10% each year, or about 10 new patients a week, primarily because of the complications from diabetes, but also of course because of the aging of our population and the higher percentage of the population that is elderly.

Obviously, the financial implications of this kind of growth are staggering. Dialysis treatment costs between \$25,000 and \$55,000 a year for each patient, and that doesn't include the cost if they need to be in hospital. While that's merely the financial cost, the human dimension to the patients and to their families is as much a reality as are the facts and figures.

I was interested to realize that dialysis has really only been around in its perfected form for about 20 years. It's become one of those miracles of medicine that we easily take for granted if you don't have to rely on it, but for those who do have to rely on dialysis, there's the stark reality that without it, as Mr Wilson has said, people have days, or at the most weeks, to live.

Also at issue is the quality of the patient's life once in treatment. That's where the prime demand is for treatment of kidney disease through dialysis within a reasonable distance of home, because of course Mr Wilson is correct in the pressures and the problems that are faced by travelling. As well, people want treatment schedules that make the dialysis available to them when they're feeling well. They shouldn't have to wait until symptoms appear before receiving it.

It's a combination of all of these factors—both the increasing number of patients, the high cost of treatment and the need to provide appropriate dialysis treatment to patients across the province—that is putting incredible pressure on the entire system. In particular, there's been pressure on the front lines—I know in your hearings you will hear from some of the people on the front lines—on the hospitals, on the physicians and the other health care workers who are trying to meet the demand as well as manage the cost of this very specialized therapy.

That's why planning for the future is the key. I was glad that Mr Wilson acknowledged the need to do that, because we need planning that looks not only at the immediate needs but also into the future and takes it into account. Of course, we believe that this planning has to involve representatives from all areas of the health care

system: the doctors, the nurses, the patients and health planners from individual communities, as well as the ministry.

I'm distressed when I hear that perhaps Orillia was not the appropriate place to do the expansion, because that kind of a recommendation comes from the district health council, because of our belief that planning is best done if it is done in a decentralized way, with the district health councils being the bodies that make the recommendations with respect to the needs and how best to meet those needs within their various areas.

I think it's worth reflecting on the progress that we have made in some other areas of health care, because it wasn't very long ago that the health system faced a significant problem of waiting lists for people needing cardiac surgery. I'm delighted to be able to say that this is no longer the case. Just last week we discussed in the Legislature the study that had been released by the provincial adult cardiac care network that shows that Ontario is now a leader in cardiac care.

Compared to the late 1980s, cardiac resources are now being used more efficiently and priority is being given to the patients requiring urgent treatment. So the average waiting period for cardiac surgery has decreased tremendously. In fact, the study shows that it now stands at just over a month. That's a turnaround that didn't happen by accident or all by itself; it's the result of careful planning that involved individuals from throughout the cardiac treatment system.

So I think the message from this is very clear: It is that if planning can make such a dramatic difference to the state of cardiac care in Ontario, surely we ought to be able to plan in the same way to deal with people with kidney disease.

We've already identified three key areas where the kidney disease treatment system needs attention.

First, we need more specific data collection, tracking such things as the number of people who are in the early stages of kidney disease and do not yet need dialysis. That's the kind of data that can help us to better plan for future needs.

Second, we believe we must work with doctors and other health care workers to come up with some guidelines concerning dialysis treatment. For example, when's the most appropriate time to begin dialysis? What's the most appropriate type of treatment—haemodialysis or peritoneal dialysis—based on the condition and the needs of each patient?

Third, we have to work—again, with the profession—to come up with guidelines for pre-dialysis care: things that could include information on diet, on blood pressure and medication, the things that we know can slow the progression of kidney disease.

These are all the kinds of issues that can be incorporated into a comprehensive planning strategy for treating kidney disease. That kind of planning has already begun, and we're beginning to reap the benefits.

The three-phase, \$22-million expansion program that we've just completed greatly expands our dialysis services. The aim of that was to bring the service as close to

home for as many kidney patients as possible. In addition to the program's basic funding of \$22 million, we added another \$27 million of life-support funding to hospital operating budgets for end-stage kidney disease services, and \$10.6 million have been spent on new equipment and renovation projects.

1550

At the end of 1988, before the expansion started, there were 2,073 dialysis patients. In December of last year, the number had risen to about 3,339 patients. That's an increase of 1,266. But after all of this additional spending on dialysis services, we can now treat 1,400 more patients than we could five years ago, which means that we're actually staying marginally ahead of the growth in patient numbers. So we're at a stage when we have more dialysis services available and accessible than ever before. That does not mean, as I've said, that we don't need to plan for a greater expansion in the future.

The expansion program that has been completed had two main objectives, and both of those were also met. The first objective was to improve access in remote communities, so we created 12 satellite treatment facilities, mostly in northern Ontario. The second objective was to meet the demand for increased services in urban areas, which is why we opened the new treatment centres in such places as Orillia, Mississauga and Oshawa.

Some other innovative approaches to community-based dialysis care have also come about because of the expansion. I suspect some of your presenters will talk more about that during those hearings. In January, for example, a new dialysis management clinic opened in Markham. This is the first OHIP-funded privately operated clinic of its kind in the province and can provide 36 dialysis treatments each week.

As you can see, we have made some substantial progress in spite of such challenges as the increasing number of people with kidney disease. But as I've said, the work isn't finished and there are still a number of problem areas, especially in the greater Toronto area. That's why we've been focusing our attention on this particular part of the province. We recently provided \$100,000 to the six district health councils in the central region to conduct a comprehensive review of the need for dialysis. I expect to have that report by the end of this summer. I also expect the report to make recommendations in a number of critical areas, including how to meet the increasing demand for dialysis services, how to improve geographic access to services and how we can ensure that existing resources are being used as efficiently and effectively as possible.

Between now and the completion of this review, the ministry will continue to work with existing facilities to make sure that adequate services are always available to dialysis patients. The results of this new stage of planning, combined with those of the three-year expansion program, we believe will greatly improve treatment options for kidney patients throughout Ontario.

As I said at the beginning, while dialysis treatment is critically important, it's only part of the challenge of kidney disease, because another important challenge is prevention through the promotion of healthy lifestyles.

On the prevention front, we've introduced programs which raise awareness about diabetes and the steps that can be taken to reduce its incidence. In northern Ontario, we already have one such program that targets aboriginal people, who tend to have a much higher rate of diabetes than the general population, and we're setting up a program for aboriginal people in the south. Other public education campaigns are aimed at curbing kidney disease and focus on such life factors as nutrition and cardiovascular health, especially hypertension.

For people who already have kidney disease, however, the best option is a transplant. Transplants can lengthen life. In addition, transplants can save the system a great deal of money. They cost between \$40,000 and \$45,000 or the same as, in some cases, one year of haemodialysis. But transplants can't happen without the donation of organs. That's why we provide \$1.5 million in annual funding to the multiple organ retrieval and exchange program to promote organ donation and to coordinate the transplant system.

MORE puts together awareness programs for families and health professionals and operates a computerized registry to match potential donors and recipients. It also organizes Organ Donor Awareness Week, which starts on April 17. Regrettably, we do not have sufficient donations of organs to meet the need in the province. I hope that all members of the Legislature will use Organ Donor Awareness Week as an opportunity to do some work in our constituencies to spread the word about the need for more donations.

I believe that all of these efforts mean that we'll be better able to provide for the needs of people with kidney disease. It will take time to create the perfect system, but I think it's clear we're on the right track, and I hope as these hearings proceed you will hear some support for what we're doing and some constructive advice as to how we can improve.

Our overall strategy for the Ontario health care system is to ensure that services are appropriate, affordable and sustainable. To help achieve this, we're looking to communities, listening to them to find out what their needs are and involving them as full partners in the planning process.

We believe that the people of Ontario deserve the very best in health care, and that includes the increasing number of people suffering from kidney disease.

It's certainly my hope that, as in the case of cardiac care, we can deal effectively with the service problems dialysis patients have faced, and I hope that in a few years we'll be reading another report that identifies Ontario as a leader in preventing kidney disease and, when necessary, treating people who have it.

That's our goal, and I very much welcome the opportunity provided by these hearings to have some comments on that goal: how well we're meeting it, by how much we're missing it and, as I've said, some constructive suggestions as to how we can plan better in the future and how we can help communities to do that planning, because we remain firmly convinced that working with the district health councils, with the consumers and with all the participants in the system is the way in which we



have to ensure that our planning produces solutions that are effectable, affordable and sustainable.

I thank you very much for this opportunity to participate briefly. I will, from my own staff who are here, be receiving reports of the hearings, and I will look for your conclusions with interest.

**The Chair:** I'd like to give Ms Sullivan an opportunity to comment briefly and then, would you have time for one or two questions? I know you have to go off to another meeting.

**Hon Mrs Grier:** I'm afraid I have to be at policy and priorities board by 4, so I only have a moment or two, but perhaps I could hear Ms Sullivan's opening remarks. I promise you I will read them in Hansard tomorrow.

**Mrs Barbara Sullivan (Halton Centre):** We all know there is not only a crisis in access to dialysis in Toronto, but there's a growing crisis and a disparity in equity of access to dialysis across the province; that the most rapid increase in rates is among those people who are over 65 with vascular disease or diabetes, and indeed that's also a growing part of the population. Therefore, when we're looking at this issue and comparing the demographics of the disease, we have to understand that this is not a crisis that is going to go away quickly, that it will continue and had better be planned for in terms of not only today but for tomorrow.

I believe we are seeing a rationing of services without having had a public discussion with respect to the rationing of those services, without determining the nature of where or how the rationing should occur.

I also believe that because of the current situation we're indeed spending far more money than we ought to. We know, by example, that in Toronto patients may spend up to two and a half months in hospital because outpatient facilities don't exist. We know that in October 1993, I believe, Dr Mendelssohn reported that in Toronto there were 13 patients who couldn't be discharged from hospitals because they had to stay in while they were waiting for a cancellation to get on to a dialysis machine. We also know that the kind of stopgap announcements that have been made—by example, around the same time, when the minister indicated that the transfer of funds from the Sussex Centre would relieve some of the stress in Toronto, that was a very temporary, short-term situation. In fact, I would be very interested in knowing if any of the money was transferred. The Sussex Centre was supposed to open in 1993, didn't, and therefore the money was clearly on the books. In other words, there was no new commitment to facilities.

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One of the things that concerns me, however, is that if there is not a full, complete strategic approach to end-stage renal management, we will never reach the point where we are providing full, fair, appropriate and effective care to people across Ontario. The evidence has been available for years that a full, comprehensive strategy is required, a full, comprehensive program is required, and it is not only the fault of this government but of previous governments that this has not been put into place.

Dialysis is only one aspect of the problem. We certainly

know that transplantation is far more cost-effective and perhaps has, in many cases, more of an outcome benefit to patients. The entire issue of organ donor encouragement has to be dealt with. I have not seen the current government or previous governments come to terms with dealing in a public manner, through public discussions, with some of the kinds of presumed-consent or other consent initiatives that perhaps ought to be looked at in Ontario.

We have added to the witness list for this committee many people who will not only discuss the dialysis issue, but who will put the whole question of end-stage renal disease into a context of a comprehensive strategic program and policy. In the meantime, we see an awful lot of dragging of the heels. The minister indicated with respect to dialysis that a committee would be set up to discuss some of the issues. I've been told as recently as March 29 by Dr Roscoe that the committee which the minister referred to in the House following one of our questions has met on only one occasion, and that was on March 22. It was a 16-member steering committee with no nephrologist representation. You can't deal with the issue unless you've got the players at the table.

Those are some of the things we want to explore as the hearings move along.

**The Chair:** Before turning to our witnesses who are here today, I would note that the ministry has circulated a document called Ontario Renal Disease Planning and Services; that is background information for committee members.

DAVID MENDELSSOHN

**The Chair:** We will begin with our first witness, Dr David Mendelssohn, a nephrologist at the Toronto Hospital. Dr Mendelssohn, if you'd be good enough to come forward, welcome to the committee. Help yourself to some good Queen's Park water. Once you're settled, please go ahead. I take it the slides are yours. Mr Wilson will operate the lights at the back.

**Dr David Mendelssohn:** Thank you very much for inviting me to be here today. I'm very glad to have the opportunity to share my expertise in the area.

I've been mainly involved in the Metropolitan Toronto problem—I work across the street at the Toronto Hospital—and my comments will be mainly around the issues related to Metro Toronto. Let me add at the outset that the problems I will discuss in Metro Toronto are perhaps more severe, but similar pressures are faced in other areas of the province as well, and I believe most of what I say is generalizable.

I also want to say at the outset that I'm glad to hear the minister acknowledge that there is a problem. Once a problem is acknowledged, I think it's fairly easy to get talented people in a room together to get answers and solutions, and I hope that's where we're going.

This is what I call the dialysis dilemma. It's a problem facing governments who fund dialysis all over the world, that is, that somehow society has to come up with a way to provide access to dialysis and quality of dialysis, while the anchor dragging the whole system down is the cost of dialysis. In Canada and in Ontario, once people are on

dialysis, quality is at a very high level. The problem is with access, getting into the system.

In the United States, they face a different problem. You may not know, but the US government in 1972 decided to fund dialysis for everyone who needs it there, so it's one of the only diseases that can be compared fairly directly to the way we provide medical care in Canada. They've also had incredible growth, and they've struggled by decreasing quality but maintaining access. So they don't have a perfect system either, and both governments in both parts of North America are struggling with this.

We've already heard some cost estimates, so let's deal with that first. This slide shows the cost of dialysis. As was explained before, this does not include any in-hospital costs or any physician fees. You can see that the cost of centre haemodialysis approaches \$50,000 per patient per year, and the bulk of the cost is labour. The rest of the costs are fairly fixed. You will probably hear some alternatives to providing dialysis at a less costly rate, but it's very difficult to see where substantial savings could accrue. Certainly some savings are possible, but I'm not sure where dialysis can be made a lot cheaper.

Home dialysis, as you can see, is quite a lot cheaper, mainly because you've eliminated a lot of the labour costs. However, with home peritoneal dialysis, it's the supply costs that are now substantial. The supplies are delivered to the patient's home.

This is the growth of the dialysis population in Toronto region. Toronto region stretches from Orillia in the north to the Credit River Valley in the west and to Oshawa in the east. You can see that the number of patients grows steadily and very, very predictably, averaging about 10% per year. We were up to 15% in 1992, and it's projected to continue to increase. We also heard today already that this is a young science and that this is the reason behind it. In other words, in the 1960s and early 1970s, only young and healthy patients were referred. Criteria were liberalized and the technology improved so that now we accept gladly diabetic patients and elderly patients, and we're just starting to catch up with the real need out there. So it's very easy to make projections of what is needed beyond 1993.

Since we began tracking this statistic in 1991, we've been calculating basically what we've been budgeted to provide with what is actually given in haemodialysis in the Toronto hospitals. This is a composite figure showing that in Toronto all adult hospitals since 1991 have been operating at more than 100% of capacity, and it's slowly getting worse. The theoretical standard is 85%; a haemodialysis unit should not be full. You have to be able to accommodate work schedules, acute renal failure, unexpected referrals. All sorts of things crop up, and you have to have flexibility.

What this means is that, for example, in my hospital this morning we had a list of about six patients whose dialysis treatment had to be changed and postponed because we had more pressing emergencies to deal with. That's playing a very dangerous game of brinkmanship. If you postpone the patient, the patient may be okay, but

they may not be okay. We've started to see complications arising on a fairly regular basis because we've postponed somebody's treatment for 24 hours.

Because of this very, very predictable growth, it should be easy to make plans and to have working groups dealing with the problem and bringing facilities on line as the need is there. You can see that this is basically haemodialysis patients, 1992 actual and projected beyond that, assuming 9.8% annual growth per year. We also know that you need one haemodialysis station to serve basically five patients or so. In the region right now we already have the most patients on peritoneal dialysis compared to anywhere in the world with similar demographics, similar wealth and similar population. We already have more patients on home dialysis methods than anywhere else.

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Despite that, roughly half the patients are going to need haemodialysis, and you can draw a graph predicting that the red line should really continue to increase as well, but in fact there has been no haemodialysis expansion planned for 1994 or beyond. We heard about the Sussex Centre. That came on line March 1. That's included in the 1993 statistics because that's where it was supposed to go, and there is no additional growth for 1994 or beyond.

It's easy to see that this gap between the growth and what's been given will continue to grow unless there are both short-term solutions and long-term solutions. I'm all for central-east planning committee and long-term solutions; I'm very concerned about what we're supposed to do in the short term with the problem we now face.

At some point it becomes a fairly philosophical issue. In other words, what is the appropriate level of treatment in a country like Canada? Here is a graph basically of wealth along this axis and the number of patients being treated for end-stage renal disease. There were 35 countries on this graph originally, and I've simplified it only to show you that the United States and Japan are the leaders in terms of generosity, providing for everybody who needs this technology.

Canada does similarly to a lot of other western nations, and in the Third World, of course, people with end-stage renal disease just die. For example, in Russia less than 1% of the patients who need this actually get it. You can see that in Canada we do reasonably well, but we still, for our wealth, don't do as well as perhaps we should do. For example, Israel, which is a poorer society, actually treats more patients than we do.

You can see that this gap between what we do and what is done in the United States means that even 10% per year may be an underestimate. In other words, rationing means we are not treating patients who might benefit, and this is a direct comparison of dialysis rates, incidence rates of end-stage renal disease, compared to age in Canada, compared to the United States.

First, perhaps we should look at the American white totals, because the black population skews the American averages. If you look at the far column, the rate for American whites, you can see that at every age group



there's a substantial gap between what we're doing in Canada and what is being done in the United States, and the gap is greatest in the elderly. In the United States, if you're 75 years old or over, you have more than twice the chance of receiving therapy for end-stage renal disease than we currently have in Canada.

What rationing means is that if someone has end-stage renal disease and they want dialysis and they would benefit from dialysis, if they're not offered it, that is rationing. I believe society has to grapple with whether we are going to sanction rationing in a public manner and create criteria. Right now, we as care givers have no criteria and we have no reason to say no to anybody. We just try to slot them into positions that just aren't available.

The problem and the solutions are not easy. For example, we've also heard this morning about an increase in transplantation rate as being the best solution, and I wholly agree. It's the most cost-effective and it offers the patient the best quality of life. If we could succeed in doubling or tripling transplantation rates, we might not have to have hearings such as the ones we have today to discuss what to do about the dialysis crisis. I hope we can have some honest debate about presumed consent and other imaginative ways to increase the transplantation rate.

The other ways are more difficult. They involve more money, reallocation or whatever word you want to use for it, to go to dialysis, or else to say that we just can't afford it. And if we can't afford it, we have to begin a public debate about rationing of dialysis. It has to be explicit and open and publicly debated and sanctioned by the public so that we could tell patients and families that they are or are not eligible for dialysis.

I just want to conclude that I realize this is an enormously difficult area. We're at a time when the economy is sagging and the health care pie is shrinking. So fiscal reality dictates one thing, and yet dialysis doctors, dialysis nurses, dialysis patients who are going to appear before this committee are going to be telling you that the dialysis slice of the health care pie needs to be expanded.

I don't think nephrologists should be the ones who decide; I think society should decide, through our elected representatives. I hope you can find your way through the muddle I'm sure you're going to be hearing in the next couple of weeks.

I'll conclude there and I'll be happy to answer questions.

**The Chair:** Thank you very much, and for your slides as well, which help those of us who are not as aware of the terminology and some of the statistical data to better understand what's happening. We have some time for questioning. I'll begin with Ms Sullivan.

**Mrs Sullivan:** I'm very interested in the presentation you've made, Doctor, particularly in the questions you've put forward with respect to determining how rationing should occur. You said that doctors ought not to be doing that on their own.

I'm also interested, however, in your discussion of where appropriate standards for various kinds of dialysis

should be put into place and how they should be put into place. I'd like to start there with a question: What, if any, appropriate peer process is in place now with respect to establishing those protocols and standards?

Then, moving on to the issue of rationing, what recommendations would you have with respect to how a society can come to terms, if assuming rationing, with a discussion surrounding those rationing issues?

**Dr Mendelsohn:** First, with respect to criteria and standards, currently there basically is nothing. We assume that the Canada Health Act applies and that dialysis should be available to everyone in Ontario who might benefit from it. If patients are referred to us, we bend over backwards to make sure they get something, even though we're full.

We have frank discussions about quality of life on dialysis. With patients who have associated diseases who may not do well, we try to put all the facts on the table for patients to decide, but we believe that in 1994 a competent patient who wants dialysis, knowing what they're getting into, should be offered it.

In terms of standards, the Kidney Foundation of Canada is helping to create the conditions whereby there is a working group for renal services in Ontario creating standards of care in the areas of pre-dialysis, haemodialysis, peritoneal and transplantation. It's a multistakeholder group, including government, hospital, nurses, physicians, and we've grappled with some of these issues, but, again, mostly the people are stakeholders, and I'm not sure at the end of the day, if we're going to limit access to this technology, whether our opinions are more important than broader society's opinions.

The other part of the question was, how should this be done? I'm not sure how it should be done. I know it should be done publicly, and I also feel very strongly that patient groups and care givers in this area should have input into the process.

So you could hear my opinion, while I'm here and while probably no one's going to interrupt me, I'll give you briefly my opinion, which is that, in general, we could dialyse effectively almost anyone. We should, in my opinion, have a liberal intake policy so that everyone is given a chance to benefit, and then we should reassess it after two or three months and say: "Okay, you're not doing so well; your suffering is great. Perhaps we should have a discussion about stopping this therapy."

That's my own opinion about how it should be done. There are at least some principles that most nephrologists would agree with. For example, I'm not sure we should be dialysing irreversibly demented people. But when you get to more difficult areas, it's very difficult to achieve any consensus at all, even among nephrologists.

**Mr Jim Wilson:** Thank you, Dr Mendelsohn, for not only appearing today and the work that you've put into your presentation, but really for your leadership on this issue. I want to thank you on a personal note for attending a public meeting in my riding some three weeks ago. That was not only a great information session for patients and me myself, but also I think a great morale booster for

the community that someone of your prestige would come to little old Alliston and try and help us out in finding solutions for this crisis.

A lot of politicians, as you know, continue to go around saying there are no user fees in the system and that we don't ration. I'll leave user fees for questions of the actual patients who are paying those user fees now, but with respect to rationing now, how bad is it and how are you doing it now, when, as you've testified and as we've heard from the minister, there aren't really written criteria?

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**Dr Mendelsohn:** We have only indirect evidence of rationing right now. As I said before, patients who are referred, we make room for or we transfer them outside Toronto region if we can't make room in the Toronto region. We have concerns that if rationing is occurring, it's occurring in the communities at the point of referral. In other words, some doc has a couple of patients and knows that Toronto is full. So they either don't call us at all or they only tell us about the young healthy patient and not about the elderly patient.

I have anecdotal evidence; I can tell stories. The actual scientific evidence is lacking at the moment. We have information like I showed you, comparisons with the United States. We know that rationing will not be occurring when incidence rates plateau. In other words, every year it goes up, up, up, up, which means we haven't met the need yet. When it plateaus, we could make the assumption that the need is being met. So because it's going up, up, up, that's another indirect evidence of rationing. Exactly how and why it's occurring in the community is a matter for study, and such a study is under way.

**Mr Jim Wilson:** In your solutions list, number 1 was increasing the transplantation rate. It's my understanding, though, that in recent years the number of transplants in the province has really plateaued. How much faith do you put in being able to increase the rate in the near future? That's my first question on that. Secondly, can we talk a little bit more about short-term solutions? Because you know, the government's response to this whole thing is the central east dialysis study. The minister has indicated she hopes that will be finished at the end of the summer, but in the meanwhile people are suffering.

**Dr Mendelsohn:** Yes. The fall in transplantation rate is also not an Ontario-specific problem. It's all over the western world and it relates to things that have been good for society, such as seatbelt legislation, drunk driving programs and that sort of thing. So you're right, the transplantation rate has plateaued or even fallen.

Whether it could be increased in a big hurry, I agree with you: It cannot be. We rely now on voluntary signing of organ cards and voluntary donation. We've relied on public education in order to get the message across, and in my opinion we've plateaued in that area and it's unlikely that it will increase.

I think the way to increase it is with a legislated solution, such as presumed consent legislation, where if you don't sign your driver's card, if your choice is not

known, it's presumed that you've consented and the organs will be taken. That's been done in parts of Europe and has succeeded in doubling and tripling transplantation rates. Whether such a thing would be acceptable in Ontario or not is an open question, but I think it's something society should debate, and certainly education would need to be part of a legislated solution along those lines.

You're right; it's not a quick fix. The quick fix is to see where the system can be expanded enough to cope with patients who are coming in the next year, to start plans now for expansion, if not in 1994 then certainly in 1995, and there should be a systematic expansion plan in place bringing dialysis closer to the communities where it's needed.

**Mr Jim Wilson:** If I may, Mr Chairman, very briefly—

**The Chair:** One final.

**Mr Jim Wilson:** —on the latter point there, bringing dialysis closer to the communities where it's needed, your opinion of satellites as a partial solution, my great fear—and I think you share this—is that the study the government's undertaking perhaps will simply look to expand current dialysis centres, which are essentially hospitals. Could you just comment on your opinion of satellites and the feasibility of them?

**Dr Mendelsohn:** It's sort of ironic that the pattern in the region is that we grow and grow until we burst and then there's a Band-Aid. The Band-Aid is always increasing where it's easiest to increase, which is in the downtown centres, and then we hear the government complain that all the dialysis is in the downtown centres and there's none in the communities where it's needed. So it's like a catch-22.

I agree with you: It's likely that the Band-Aid here will also be in the downtown hospitals. We as nephrologists are all in favour of dialysis in the communities and satellites in the communities. There will have to be a careful selection of patients so that the patients are well enough to be visited less frequently by nephrologists, but certainly those who are able should be dialysed as close to home and as close to work as possible.

**Mr Paul Wessinger (Simcoe Centre):** Thank you, Dr Mendelsohn. You've touched on some of the areas that I was going to cover. But what I was going to ask you is, I've been told that dialysis can often be done outside a hospital setting and at lower cost than within a hospital setting. Would you agree with that statement?

**Dr Mendelsohn:** Firstly, the home peritoneal dialysis method which has been discussed today is done largely outside of hospitals for less cost, no question. I've already said that we already have the highest percentage of patients receiving that therapy in the world. There are criteria to make patients acceptable for that. We feel it's already at its maximum. In fact, we feel we have patients whom we leave on that therapy who should be switched to haemo whom we can't switch because we don't have haemo. So that's that.

Now, can haemo be done outside of hospitals? The answer, again, I think is yes. We are already doing that



at Sheppard Centre and Sussex Centre. That is full self-care. So that requires patients who can learn to do needling themselves and care of the machine themselves.

I believe there's also a need for an intermediate category which would be called, perhaps, assisted self-care, where a patient could turn up, have the needling and machine care done for them, but basically it's outside of hospital and costs would be lower.

As I mentioned, it's hard to see where costs would be an order of magnitude lower. They could be perhaps 10% or 15% lower, which is a substantial saving none the less.

**Mr Wessinger:** Do you see any new technology developing that may perhaps provide more alternatives for in-home treatment in the future?

**Dr Mendelssohn:** One of my colleagues is working on an overnight type of haemodialysis that would be done at home with patients monitored in a central station by computer. That is perhaps one way. But I think the excitement in the area of kidney disease is largely in the area of organ transplantation and either complete artificial kidneys or perhaps crossing the species barrier and being able to use pig kidneys, for example, for humans, which would again make a tremendous difference in the number of patients who need dialysis. But I don't think either of those is likely to occur in the next two to five years, which I think is the time frame we're most interested in.

**Mr Wessinger:** Fine. Thank you very much.

**The Chair:** Mr Rizzo, did you have a question?

**Mr Tony Rizzo (Oakwood):** Yes. From what we heard this afternoon, apparently the kidney transplant is the less costly, most effective solution to the problem. But where would you get the kidneys if that's the case and how costly would they be? What market? Would you go to the international market to get them?

**Dr Mendelssohn:** I personally find the idea of buying organs on an international market—morally it doesn't sit quite right, although you could make very interesting and eloquent moral arguments either way. I think it's probably beyond the scope of this group.

I think that the organs should be from Canada, from Ontario. As I said, if society had a presumed-consent type of law, I think that it would succeed in increasing the organ transplant rate substantially.

It would still leave a big problem on dialysis. I don't want people to think that it would cure the problem, because as the dialysis population grows older and older, they are less likely to be able to have an organ transplant. But it would certainly help substantially.

**The Chair:** Thank you. I wonder if we could ask you, just at the end of your testimony, for reasons of understanding some of the terminology, what in simple terms is the difference between haemodialysis and peritoneal dialysis.

**Dr Mendelssohn:** Sure. First of all, dialysis in general means replacement of kidney function artificially. So haemodialysis is the artificial kidney machine that you've probably seen on television, where blood actually circulates from the patient, goes to a machine, gets pumped around, and then gets returned to the patient.

Peritoneal dialysis refers to a completely different process where basically a tube is put into the patient's belly and the patient runs fluid in and out of the abdominal cavity to clean the blood. So they basically take out dirty fluid that's been left in overnight, they run in clean fluid first thing in the morning, and then they go about their business until lunchtime. They repeat the process. The usual management is four such exchanges a day: breakfast, lunch, supper and before bed.

**The Chair:** Thank you very much for coming before the committee today. We really appreciate it.

JACKIE ARCHIBALD

COLLEEN ROTH

ISABELLE BATES

**The Chair:** I call on Ms Jackie Archibald. We have down as well Mr John Archibald who I gather cannot be here, but Ms Colleen Roth is going to be appearing, and also Ms Isabelle Bates. If the three of you, who I gather are together, would be more comfortable coming forward together, that's fine with us. We'll simply hear you together and then ask our questions.

Welcome, all of you, to the committee. Perhaps at the outset we might start with Ms Archibald. If everyone would be good enough to introduce themselves for Hansard and also for those watching on television, that way they'll know who's who. Just before you do that, members of the committee, if this is agreeable, I would let each of them make a presentation and then we can combine our questioning to any of them after that. Ms Archibald, we'll start with you.

1630

**Ms Jackie Archibald:** Hi. My name is Jackie Archibald. I'm from Beeton, Ontario. I'm a coordinator for the Critical Need for a Dialysis Centre in south Simcoe county.

A couple of things today: We're here to propose to establish a satellite-based kidney dialysis centre in the south Simcoe area. This has been the most ongoing critical situation occurring in the south Simcoe area and the public affected by patients and all involved in this plead for a facility.

Most kidney patients who require haemodialyses are travelling to Metropolitan Toronto three times weekly at the cost of their ailing health and their pocketbooks. I'm one of those people. My mother has polycystic kidneys. She's been on dialysis for two years now. I also have a respectable job that I attend five days a week, but I had to take my mom to Toronto three times a week; 12 hours a day we were gone.

We were able to get a home dialysis machine in our house, but unfortunately there was no funding; my father's paying for that. It's costing us approximately \$400 a week to have the nurse come to the house to dialyse my mother. She has improved by having dialysis at home, but at the same time the financial burden is so strong on my father that he can hardly cope any more.

I need a drink.

**The Chair:** Go ahead, there's lots of water there. Take your time.

**Ms Archibald:** I'm not used to speaking in front of all you people.

I've put together a book here that I'd like to leave for you people to look at—I know we only have 10 minutes—and the literature that we've gathered. In the public meetings that we've had up there to have a satellite, we've had over 200 people attend our meetings.

I was also diagnosed in December 1993 with polycystic kidneys. I've been in and out of the hospital seven times since 1993 to this year, Wellesley Hospital being the hospital for treatment. I'm 33 years old. I have three children at home. I can't come to Toronto to be dialysed when my time comes.

We're proposing that the Ministry of Health take a serious look at putting a dialysis satellite in the south Simcoe area for these patients. Like I said, I've put together a book here for you to read. There are letters from patients. I have signatures from patients who would come to the clinic or the satellite. I have a lot of information gathered for you. I just can't get it all out right now.

**The Chair:** Thank you. We'll take that and make some copies and make sure that everyone in the committee has an opportunity to see that.

**Mrs Colleen Roth:** I'm Colleen Roth. My father is Alvin Hiltz from Alliston. He has to go three times a week to Toronto on a bus leaving at 8 o'clock in the morning and coming back at 8 o'clock at night. He is 70 years old. My mother is 68 and she has to accompany him because he can barely see, so he cannot see the taxi fares. They have to get a taxi from the Bay Street bus terminal to Wellesley Hospital, where he has to go for four or five hours' dialysis. It is deteriorating his heart and her health condition.

At a meeting in Alliston, we were all sitting there, me and my sister and my mother and father, and my father openly spoke out and said he was giving up on life because he could not struggle with this travelling back and forth to Toronto any more. That's why we're trying to get a satellite dialysis in the Alliston area, for the patients up there. That's all I have to say.

**Mrs Isabelle Bates:** I'm Isabelle Bates. I'm the president of the south Simcoe chapter of the kidney foundation. I only came along; I didn't realize I was going to have to speak. I'm only here realizing what we are asked to give for transportation for these patients. Our chapter: Our money comes from our March drive, we have a fall dance, we have peanut sales, we have a raffle on a beautiful afghan and in memoriams. Out of that we also try to put a lot to research. This year, to my knowledge, to the Orillia unit, we have had to open up a bank account for transportation for these and it's running a lot less for research, believe me. That's all I have to say.

**The Chair:** Thank you for coming. We have a good bit of time for questions. I'd like to say as well that with the time that is available, if as we go along there are some other things you wanted to say but forgot to say, please do so. The purpose of these hearings is to hear what the issues are, what some of the problems are and, quite frankly, without your presence we can't know and understand that. If, as I say, as we go along there are

some other things, please jump in with those. We'll start the questioning with Mr Wilson.

**Mr Jim Wilson:** Thank you very much, Jackie, Isabelle and Colleen. We have a good portion of time here for questions, so perhaps through some of my questions we can further explain to the members what your families are going through and what we're going through locally.

Jackie, I want to start with you and to thank you. Your family has been instrumental in the south Simcoe area, in the New Tecumseth area, in organizing the public meetings. I want to thank you publicly for that. We have had, so that members will know, a couple of major public meetings that have been referred to. Over 200 people showed up to the first one and a substantial number to the second one. The interest has been incredible. There are a number of things I want to pursue with you, Jackie, about what's happened at those meetings.

The first one, though, is your father, John Archibald, who's unable to be with us today, and that's probably because he's trying to keep the business together. Perhaps you could just explain what's happened there. Your mother, Anne, went on dialysis. Give us a little history of when she was going to the hospital and why she desperately needed to get home and the time she was in the hospital, and a little more about the cost because I know your father has said to me directly that he thought we weren't supposed to have user fees in the system, yet he's paying \$400 a month, so just a little bit of history of what your mother's been going through.

**Ms Archibald:** A week.

**Mr Jim Wilson:** A week, sorry, yes.

**Ms Archibald:** When mother was diagnosed in 1991, she was put on the CAPD from Wellesley Hospital by Dr Janet Roscoe. She went on that and then slowly lost the use of her right side. She became paralysed and was falling all the time and couldn't get up, couldn't do anything; actually, she was bedridden. I had had enough at that point. I phoned an ambulance and had her admitted to the hospital and told them I was not bringing her home until they did something for her.

She was left in Wellesley Hospital for three weeks. Again they didn't do anything. No tests were run. They just kept her in bed, dialysed her, put her back to bed, dialysed her, put her back to bed. So I went down to Wellesley Hospital and I raised some stink and said: "What are you going to do? You can't just leave her there to rot, you know. She needs intense therapy. She's a fighter. What are we going to do?" Dr Roscoe made a couple of calls and within a couple of calls and within a couple of days I had her to Riverdale. She was in Riverdale Hospital for three and a half months being dialysed and under intense therapy, and again, like I said, she's a fighter; she came around.

**1640**

At that point the doctors decided that a machine could come home. She qualified for a machine in her house. My father and I thought, "Great." It really boosted mother up and her morale, her spirits, her health, her blood pressure, everything started coming together.



We received the machine in the House. Dad put a new floor in, did a room for them. The machine came. At that time we thought all expenses were paid for through the Ministry of Health. We came to find out it wasn't: lack of communication. Dad couldn't very well take the machine away from mother because it was keeping her alive. She came around 110%. He has to pay for it out of his own pocket, which runs him between \$350 and \$400 a week. With the economy being the way it is, and the business, he's come from a two-income family down to a one, and he goes to work to come home to hand his paycheque over to the nurse.

**Mr Jim Wilson:** How old is your mother?

**Ms Archibald:** Fifty-three.

**Mr Jim Wilson:** Fifty-three, and prior to being stricken with kidney failure she was in good health and she was the second income, is that right?

**Ms Archibald:** Yes.

**Mr Jim Wilson:** With what's happened at the public meetings, there's been a tremendous petition campaign in the local area, which you've helped with and Colleen's helped with and Isabelle's helped with, and many people have. I've been presenting those petitions in the Legislature, but in addition to that, can you explain to the committee perhaps what some of the initiatives have been.

I'm thinking, for example, of the service clubs that have been at the public meetings and said, "We will do whatever it takes to raise money to put a satellite in our area." They're frustrated because the ministry has said, "Even if you raise money now, we wouldn't know what to do with it." Can you just confirm for the committee that the local communities are willing to raise the money for the machines or the office to put in a satellite and explain some of the frustration we're feeling with respect to the government's foot-dragging on this issue.

**Ms Archibald:** Even myself, I'm really confused too. I have a job and I've put a lot of man-hours and a lot of legwork into the research here, and yes, our community is behind us and we want to go on and carry on and get together and raise money, but the ministry is holding us back by saying we have to wait till this planning's done.

I've had a couple of lists. It's not up to date because one of the patients who was called had passed away, but we could provide some of that information to the ministry. I have a lot of information. I don't think we can wait and wait and wait. We were told in September that the planning was going to start and we were waiting for an answer in March and now we hear today that it'll be by the end of summer. Then the end of summer's going to come. We don't have 12 years.

I'm not coming to Toronto to be dialysed. I have three children. I can't walk out of my job and go on social assistance or welfare. Who's going to look after my kids? If I'm home or close to the area, I'm gone for four hours or four and a half hours a day, and I can be home and I can still go to work.

**Mr Jim Wilson:** My last question for you, Jackie, is, it was your mother who in the south end of the riding brought me up to speed on what the situation was with respect to dialysis patients and I remember her saying to

me she couldn't understand for the world why she couldn't share her machine when she got it at home.

**Ms Archibald:** Absolutely. I agree.

**Mr Jim Wilson:** Has she been given any reason why she can't share her machine?

**Ms Archibald:** No, none. We've asked and I've asked at Wellesley Hospital too and they said that's her machine and other patients are through other hospitals and it's a different machine. Well, it still does the same thing. My mom's machine sits empty Tuesday, Thursday and Sunday and half days on Monday, Wednesday and Friday. Two people could be dialysed six days a week with one machine and one nurse.

**Mr Jim Wilson:** How much time do we have?

**The Chair:** We have another 15 minutes.

**Mr Jim Wilson:** Could I ask one question to Colleen? I think it's important, and I raised it in the Legislature three weeks ago. Colleen's father's name is Mr Alvin Hiltz, as you've told us, Colleen. I thought it was the most astounding thing I'd ever heard at a public meeting, and didn't think I would ever hear that in my time in either public or private life: that, when there were over 200 people gathered in the seniors' hall in Alliston, your father would get up and say he was essentially giving up on life. Can you tell us what effect that's had on the family?

**Mrs Roth:** A tremendous effect. I have a three-year-old daughter and I would like her grandparents to see her grow up. And if they don't get the dialysis, if he has to travel, I don't think he'll make it past the summer because he won't be able to take the heat, and neither will my mother, and they're going to lose out in seeing my daughter grow up. It's killing all of us thinking that we're one day going to find out we have to go to our parents' funeral.

**Mr Jim Wilson:** When, if he had dialysis, his death is preventable for quite a few years.

**Mrs Roth:** He's been on the home dialysis for nine years and it's kept him alive for nine years, so if he had to travel to Alliston five minutes away, it might, for two or three years—

**Mr Jim Wilson:** Maybe we should just explain that briefly. Mr Hiltz was on peritoneal dialysis—which is a drip bag, as Dr Mendelsohn described it—for many years, and then his condition deteriorated to the point where he had to go on haemodialysis just last year, and has been several months now driving three days a week to Wellesley Hospital in Toronto.

I think the committee should hear what his day is when he has to travel. I'll just summarize it, and you can tell me whether I'm right or wrong. He told me when I was at your house, and he told the news people, that he gets up early in the morning to take a taxi from one end of town to downtown Alliston, to catch the bus that goes to Toronto at 8 in the morning, and that bus takes about two and a half hours?

**Mrs Roth:** They get into Toronto about a quarter after 10.

**Mr Jim Wilson:** So two and a quarter hours, because

it goes through Bolton and makes a number of stops, all the little towns. Then he has to take a taxi from the bus station, as you said, downtown Toronto up to Wellesley Hospital, and repeat the whole thing at night, and he tells me he's not back till—

**Mrs Roth:** Eight o'clock.

**Mr Jim Wilson:** A 12-hour trip. What's the cost of that trip and the effect on his income?

**Mrs Roth:** It's \$40 a trip for him and my mother, and then when they get to the bus station, the taxis are around \$7 a trip and \$7 back. They're senior citizens, on senior citizen income, and it's financially draining them.

**Mr Jim Wilson:** He told me that it was the equivalent of one of their pension cheques, a full pension cheque, plus they've been borrowing money from you at the end of each month just to buy groceries.

**Mrs Roth:** Yes.

**Mr Wessinger:** Thank you for your presentation. First, a point of clarification: Your mother is on a haemodialysis unit in the home, is that correct?

**Ms Archibald:** Yes.

**Mr Wessinger:** And how long has she been on that machine?

**Ms Archibald:** On the machine at home? Since July 1993.

**Mr Wessinger:** And you indicate that she receives dialysis three times a week on her machine?

**Ms Archibald:** At home, yes.

**Mr Wessinger:** And you have a nurse come in? Would that be from the VON?

**Ms Archibald:** No. It was a nurse we hired. Wellesley Hospital said: "Run an ad in the paper. You might as well pick your registered nurse so that you're happy with her, close to home, and then she could come down here for the training and then write her exam." And that's what we did.

**Mr Wessinger:** Then I gather this isn't covered under home care, home nursing—

**Ms Archibald:** No.

**Mr Wessinger:** —that there's nothing in the program that would cover this, so any person receiving haemodialysis in the home would not have any of the nursing care.

**Ms Archibald:** Anybody I've spoken to, the hospitals are funding the nurses. There's another lady in Alliston, Eileen Richardson; her nurse is funded through the hospital. There's another gentleman in Alliston; his nurse is funded through the hospital. But my family's isn't, for some reason. There's no money, is what they told us.

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**Mr Wessinger:** So some are funded and some are not. Well, that's certainly interesting.

With the medical condition of your mother, would she have been a candidate for transplantation?

**Ms Archibald:** Yes. That's another thing: They've lost her tests and everything four times. Now I have to go back and have her all retested again. It starts in April.

**Mr Wessinger:** She is on a waiting list, then?

**Ms Archibald:** She was. The tests are lost again. They've asked for all the tests to be done again. They said they were misplaced. I'm not sure; I can't answer. She'd better be.

**Mr Wessinger:** I understand you've done quite a bit of work trying to look into the feasibility of having a satellite centre in your area.

**Ms Archibald:** Yes, I have.

**Mr Wessinger:** Is there any information you can tell the committee about what you've been told about—I understand your group has identified some patients already who would be—

**Ms Archibald:** Yes. I have some signed documentation here, signed and dated, from the patients that I can leave with you.

**Mr Wessinger:** The figure, I believe, is around seven, is that correct?

**Ms Archibald:** I have seven right now. I can get more to come in.

**Mr Wessinger:** You've been told that if you had 12 patients, that would be a viable entity for the area, is that correct?

**Ms Archibald:** That's correct.

**Mr Wessinger:** Fine. Thank you very much.

**Mrs Sullivan:** I want to pursue the question of nursing. We've heard from Ms Archibald about her personal family circumstance with respect to nursing availability and coverage. I'd like to know a lot more about that and have information in front of the committee with respect to how nursing costs are covered; if there are other alternatives; how many patients are in similar situations; and whether the hospital global is expected to cover home nursing care in a home haemo situation.

**The Chair:** You'd like us to get that from the ministry?

**Mrs Sullivan:** From the ministry or from research, whoever will be able to provide us with that information. I'd just like to have it a lot clearer in my mind.

**The Chair:** As to how the system actually works, how it's funded, organized.

**Mrs Sullivan:** Yes, and whether there ought to be some availability, through home care, of coverage in this situation or whether it indeed should be a global funding issue.

The other question I wanted to ask was with respect to the process that has been undertaken with the Ministry of Health. Have you, along with your group, gone through the routine demand steps? Have you taken the issue of the satellite centre to the district health council?

**Ms Archibald:** Yes.

**Mrs Sullivan:** And did the district health council concur with your recommendation?

**Ms Archibald:** Yes.

**Mrs Sullivan:** So they have in fact supported your recommendation to the ministry?

**Ms Archibald:** Yes.

**Mrs Sullivan:** When did that happen, do you know? Was it just recently?



**Ms Archibald:** February 20 is when I started meeting with them. I just had another meeting with Sunny Jacob on Monday night and went and spoke to him.

**Mrs Sullivan:** But there has been an actual formal recommendation from the district health council to the minister that is fairly recent? Or is it an older recommendation?

**Ms Archibald:** No, it's recent.

**Mrs Sullivan:** So it's within the past two or three days, and their recommendation included the data that you had prepared. Did they add any other material to that recommendation, do you know?

**Ms Archibald:** No, I don't know.

**Mr Jim Wilson:** Can I help out the witness on this?

**The Chair:** Certainly.

**Mr Jim Wilson:** The district health council, Mr Floyd Dale, has been involved from the very beginning. In fact, the meetings held here at Queen's Park at which ministry representatives were in attendance, along with all the local hospital administrators, Dr Roscoe and representatives of the Toronto dialysis committee, a monitoring person from Ruth Grier's office—those meetings took place last year. We've had nothing but support from the Simcoe County District Health Council. They've been at every meeting. Sunny Jacob, who's the representative and will be the representative and is the representative on the central Ontario study, has been pushing the cause.

If I could answer specifically whether an unsolicited proposal has been submitted to the ministry, the district health council has told us they think that's futile at this point, given that the consistent response from the government is, "Wait for the study." Why fill out all the paperwork, has been the district health council's view, when there's going to be a rejection and they've been told behind closed doors that there will be a rejection until the study comes forward.

**Mrs Sullivan:** That's interesting. Just while we have Mrs Bates here from the kidney foundation, I wonder if you could describe to us the kind of social supports that you see dialysis patients needing and how the kidney foundation is providing some of those supports, and where you might see other needs for patients. We've heard of the issues of transportation, we've heard certainly of the cost of nursing. Could you tell us what other areas of concentration you see the kidney foundation being able to help and where there are still gaps?

**Mrs Bates:** We, as our chapter, cannot say how much we can give. We're on a budget. So much goes to our patient services, which goes to transportation, some drugs, but it all goes down to the social worker, each patient's social worker. She or he will recommend, and then we get the bill. Two weeks ago we got a bill for \$1,800 for transportation just for four people, and just for the latter part of 1993. As of January 1, when the Orillia one opened, we have had to set up a bank account up there and put so much into it every so often. Then when it's all gone, they'll ask for more.

**Mrs Sullivan:** Then you have more bake sales.

**Mrs Bates:** No, we're not doing that. I'm willing to walk the streets banging on doors for money and selling

raffle tickets. I should have had books of tickets down here today, shouldn't I?

**Mrs Sullivan:** That's right. You would have been a winner.

**Mr Jim Wilson:** You did bring some petitions, though.

**Mrs Bates:** I, fortunately, do not have anyone in my family with kidney disease, but I am working hard for them. I went everywhere last year selling raffle tickets. People were, "Oh, not her again."

**Mrs Sullivan:** How much money would the kidney foundation raise in your area?

**Mrs Bates:** Had I known, I would have brought my figures. Last year, in the Alliston area—Alliston, Beeton, New Tecumseth, Cookstown—I think we got \$14,000 in our March drive, and I don't know exactly how much we got in our dance.

**Ms Archibald:** It was \$44,000.

**Mrs Bates:** So \$44,000, but that includes an awful lot of work—selling peanuts. It includes a lot of work.

**Mrs Sullivan:** Right, and all of that money is clearly going out almost as fast as it's coming in, in terms of assisting patients.

**Mrs Bates:** A lot goes to research.

**The Chair:** On behalf of the committee, I want to thank the three of you for coming down. The clerk will get the booklet from you, so we could copy it. Would you like us to return the original to you?

**Ms Archibald:** Oh, you can't have the original. It's my Bible. I've already—

**The Chair:** You've got a copy. Okay. We do want to thank all of you for coming and for sharing with us your personal experiences and observations on a particular part of the province.

1700

TED TOFFELMIRE

**The Chair:** I then call on our final presenter for today, Dr Ted Toffelmire, who's a nephrologist at Kingston General Hospital. Would you be good enough to come forward. Welcome to the committee. We appreciate your coming from Kingston. Would you like some water? Once you're settled, please go ahead with your presentation, and we'll have some questions when you're finished.

**Dr Ted Toffelmire:** First of all, I'd like to thank you very much for the invitation to come and address this committee, which really is focusing as a matter of its study on a matter of life and death for many of the residents of our esteemed province.

It's really a pleasure for me to get away for a day from the first federal House of Parliament and to be in this Legislative Building, and the name of this first legislative Parliament is, of course, Kingston General Hospital.

Kingston General Hospital, you might know from some of the material that's been handed out already, has been the recent recipient of approval to develop a haemodialysis unit in a shopping mall. This mall is on the outskirts of Belleville, and it's in this location where

selected eligible patients are able to dialyse themselves closer to their own home, thus avoiding the two-hour round-trip risk on the 401, especially on blizzard days, three times weekly.

You will note that this unit was opened in September 1993, and at that time 19 patients filled the 20-slot schedule, which was its capacity.

Much of the information which has been provided in the opening statements and by previous speakers is quite accurate, and it lays the groundwork for the task which is before you. I'd like to underline a couple of these issues and apply them to the situations which we face in southeastern Ontario.

On three occasions so far this afternoon, you've heard that the end-stage renal disease population is growing. This isn't new data. For the last 15 years the nephrology community, not only in Ontario but in many other parts of the world, have collected accurate information on the number of patients receiving dialysis annually, and we've seen a progressive and steady growth in this population of somewhere in the range of 10% per year.

Thus we have over a decade of epidemiologic data which really should provide us with a very strong predictive power as to what sort of numbers we're developing. It should not be a surprise from one month to the next or from one year to the next that, goodness sakes, we've reached another capacity and we have to find another way to solve the problem that has developed.

Why is this population growing? There's certainly a lack of scientific information to address this issue, although some of the factors that come into play are the improved survival of patients with end-stage renal disease; our techniques of dialysis and the quality that we provide is certainly better than in its infancy of 20 or 30 years ago; the population in our province and indeed in the world is aging, and as people get older more of their organs are failing, and certainly their kidneys are part of those organs. So more patients are requiring end-stage renal disease replacement.

There's improved survival of patients with diabetes. In past years, patients with diabetes would die of complications and side effects at an earlier age, but they are surviving longer and at this point developing difficulties with their kidneys which place them on dialysis.

Hypertension is also an issue. We don't have strong epidemiologic data to suggest that treatment of hypertension will prevent renal disease, but certainly we can see that once a person has developed early renal disease, if we can control their hypertension, they will live longer and do better.

There are certainly technical advances in dialysis. We have the ability now through some of the computerized monitors to be able to dialyse very unstable patients who were basically impossible to dialyse 10 or 15 years ago.

These are some of the reasons why the population may be growing, and there are certainly some others that I haven't mentioned.

Next, I'd like to review the position of our province with respect to the provision of health care in Ontario. Many of these data are also available in the information

circulated earlier by the ministry entitled Ontario Renal Disease Planning and Services, with the notable exception of some of the data on some of our neighbours. The country names at the bottom of this slide are unreadable from your position. On the left is Japan and the second from the left is the United States. Canada is the second one from the right, sitting right beside Denmark.

This is more on our neighbours. On the left-hand side is Canada. This is the rate per million receiving dialysis there or receiving care for end-stage renal disease. So Canada is on the left, Manitoba is the second from the left, then comes Ontario, then comes Quebec. Certainly, Ontario sits halfway between Manitoba and Quebec. You'll notice that just to our south we have New York state. New York state has approximately double the number of patients receiving end-stage renal disease therapy that we do.

The question obviously comes up: What's the difference between the people who live in our province and the people who are directly neighbouring on us? Is it that our population is so much more healthy than our neighbours' in Manitoba or in New York, or is that, for one reason or another, these patients in Ontario—the difference in the statistics in Ontario and our neighbours represents a gap that we're not filling, that we're not treating?

I'd like to summarize this material by saying that we should expect the number of patients in our communities in Ontario to require renal replacement therapy to continue to rise annually. I would suggest that this rate of growth might actually be expected to rise faster in the next few years, closer to that of our neighbours to the west or to the south.

I'd now like to spend a little bit of time introducing you to southeastern Ontario, where I would like you to come and spend your tourist dollars. This slide here is a slide of James Bay. I've put that in to remind you that Queen's University has a special historic relationship with the Moose Factory zone as far as provision of health care is concerned. So the nephrologists at Queen's care for those patients. You'll see five blue dots there. Those are patients in that area who receive dialysis under the care of the nephrologist at Kingston General Hospital.

You also notice the absence of orange dots. Orange dots are the patients who are on haemodialysis. The patients who are represented by orange dots have had to, obviously, move south, completely relocate away from their community and away from their culture in order to continue to receive their therapy.

This is a map of southeastern Ontario, the official roadways. You notice a concentration of dots in the populated areas—Kingston, Trenton, Belleville, Picton—and then a scattering of dots elsewhere. It's interesting: If you look at the number of patients on dialysis in the Kingston area compared to what you would expect across Ontario, there are certainly more patients being dialysed in Kingston than you would expect. If you go up, for example, to Bancroft here—by the way, this patient comes down to Kingston three times a week and goes back up, even in the middle of the wintertime—the number of patients in Bancroft receiving dialysis is much less than one might expect.



There's two reasons for this. The most obvious reason is that when a person in Bancroft receives the diagnosis of end-stage renal disease, they contact the moving company and make it down to Kingston, where their travel isn't quite as far. This is a routine occurrence in southeastern Ontario, although the dots that are spread out as far to the east as Cornwall and as far to the west as Port Hope do indicate that we do have patients who either prefer to travel the distance to Kingston three times a week or to care for themselves at their own home.

The issue about home haemodialysis has been raised earlier. In Kingston, we agree that the cost to our hospital of home haemodialysis is less than that of in-centre haemodialysis. As a matter of fact, the cost savings by taking one of our machines and giving it to the patient in his own home, teaching him how to use it himself, from the point of view of labour and of overhead are sufficient to pay for that machine within the first year to 18 months of therapy. So if we can predict that a patient will be on home haemodialysis more than about 12 to 18 months, that would be the financially preferable way to go. Unfortunately, many patients don't have that option because either they are incapable of learning how to run the machine or they don't have a partner to help them out. The issue of a paid helper has come up. Although none of our patients are receiving paid helpers, the hospital doesn't have the funds to support that.

1710

Some of the dots in the Kingston area as well as outlying areas are patients who are on peritoneal dialysis. There are two forms of peritoneal dialysis. There is the usual form that we've discussed earlier this afternoon, which is chronic ambulatory peritoneal dialysis where the fluid goes in and comes out four times a day.

There are approximately 18 patients in here, actually farther away rather than closer, although certainly some of them are closer to Kingston. These 18 patients do their exchanges of the half gallon of watery fluid four times a day, but they do it at night. The way they do it at night is they have a cyclor. A cyclor, unfortunately, is a capital outlay somewhere in the range of \$5,000 to \$8,000, but they are able to live their day like normal. They get ready to go to bed; they hook themselves up to the cyclor, make sure that they have hung the correct bags for overnight; they then go to sleep and let the cyclor do the job until the next morning. Next morning when they wake up, as long as there haven't been any alarms on the machine, they disconnect themselves from the cyclor and they go about their business during the day.

This is another way that patients can care for themselves at home, taking responsibility for their own care. The assisted cyclor program of this nature, where some VONs go in and do the hookups and disconnections, or some family members go in and do the hookups or disconnections, successfully keeps some of these patients off the expensive form of in-centre haemodialysis—one way of trying to reduce the labour and reduce the overhead.

Nevertheless, there are some patients who require in-centre haemodialysis because they fail to meet the requirements for the other types of dialysis, and those are

certainly the patients who have either moved to Kingston or are actually receiving their care in-centre.

One of the issues that is important to realize is the limitations of care; what limits the provision of dialysis therapy. One of the obvious ones, being a trained physician, is that if you lack trained physicians you will be unable to receive sufficient care. Certainly, this is becoming a limiting factor. I know of at least 10 openings in Canada where a trained nephrologist could immediately get a job and there are not 10 nephrologists to fill those positions. In Kingston we have five physicians doing the job of six. Even though this is a limitation, this personnel resource is dwarfed by the unstable financial resources available to us.

Life-support funding has been discussed earlier this afternoon, and I'm led to believe locally that the reimbursement of life-support requests or funds is somewhere in the range of 80 cents on the dollar. So for every dollar spent the hospital receives 80 cents back.

There is also a difficulty with the stability of this funding. In the early 1980s, when the life-support program was initiated, it was seen as being stable and the hospitals were able to expand their dialysis facilities as necessary according to patient requirement. Unfortunately, with the presence of instability in this funding and also the presence of the hospital global budgets, there has been the presence of artificial caps and ceilings on the local programs, if not intentionally or in a written fashion, at least by implication at the local level in many parts of the province, but not all.

Part of the funding issue also relates to patients who require haemodialysis or end-stage renal disease therapy from outside of their own locality. Although our furthest patient to the west here is in Port Hope, we also dialyse patients from Toronto from time to time, and that's basically when so-and-so from Wellesley Hospital or other centres calls us up and says: "This patient has a potassium of 7.5. You and I both know that they're going to be dead by the morning. We don't have the resources to care for this patient. Can you possibly take care of this patient?"

Our resources are stretched but at this point are not stretched so far as to allow a patient of that nature to die, so we do accept them in transfer. Unfortunately, some centres also tie the transfer to the transfer of funds to care for that patient. Kingston, to date, has not required transfer of funds on an urgent basis but certainly where patients are required to be cared for from out of our catchment area for a long period of time, it's incumbent upon the hospital administrators to discuss with each other just how those resources are going to be spent or transferred from one to the other.

Finally, if I might, I take this opportunity to suggest some recommendations to this committee.

First of all, I'd like to echo the minister's words in her opening statement. Specifically, she mentioned that our population deserves the very best care which can be offered. As far as I'm concerned, we must treat the patient as an individual. We must maximize their health care. We must maximize their quality of life.

We must stabilize funding.

We need a plan.

We need to offer end-stage renal disease therapy to all patients who (a) require it and (b) want it. There are some patients who don't want it. As Dr Mendelssohn mentioned earlier in response to one of the questions, some patients don't know what they're getting into when they are faced with dialysis. It is certainly reasonable to start dialysis for a couple of months—it is not an irreversible decision—and on occasion, although a rare occasion, the patient sometimes decides that the quality of life, either transporting back and forth or on the machine, is not up to the standard they require to finish their days off, so they discontinue therapy.

We can't tolerate artificial caps or ceilings, especially in the Kingston area where there's no alternative in the region. We can't call, at 10 o'clock at night, the hospital down the street and say: "We're out of dialysis resources. Could you please take over?" The hospital down the street doesn't have a dialysis unit. The one down the street is three hours away by car. The helicopter works when the weather's good.

Finally, one thing you need to consider is how much participation the patient is going to take in his own care: How much responsibility are they going to take? This is a difficult issue to look at. Some of us in health care have looked at patients very paternalistically and decided that we really may and can provide them with everything we have. This isn't the case when you go looking for a job or looking for a house. The patients themselves really should be taking some sort of responsibility in their care, and, depending on the patient and their social environment and their location of residence, this may vary among patients. Thank you for your attention.

**The Chair:** Thank you very much for the presentation. We have a number of questions, and we'll move right to it.

**Mr Wessenger:** Thank you, Dr Toffelmire. I note that you've had the experience of operating both a centre within the hospital and a satellite centre in Belleville. Is there a difference in the type of treatment that's delivered, between that in the satellite centre and that in the hospital?

**Dr Toffelmire:** The treatment is identical from the point of view of quality of medical care or exactly what type of medical care is provided. It's exactly the same machines. It's exactly the same dialyse aid. It's exactly the same needles.

There are two differences. The major difference is that a patient has to do it himself. He doesn't have a nurse there to help him. If the machine alarms or if something goes awry or a needle falls out and he sprays blood over the floor, he has to take care of it. We do have two nurses on site to take care of unfortunate eventualities, and those two nurses per shift are actually doing quite a job of doing that.

Interestingly enough, after a certain amount of training—extensive training, actually—the patients do very well, once we've selected them. We select them in Kingston by choosing patients who are medically stable

for a prolonged period of time—in other words, they haven't run into other medical complications for two or three months—and who also are capable of safely doing it themselves.

This obviously means there are some patients living in the Trenton or Cobourg or Belleville area who cannot come to Belleville for dialysis; they have to come to Kingston because they don't meet the criteria. But if they do meet the criteria, they can do it themselves in Belleville.

Two of the advantages to the Belleville unit or to the self-care unit—I wasn't going to mention the improved finances. The two advantages from the patient's point of view are, first, that there's an awful lot more flexibility. They don't have to be at Kingston at 6:30 in the morning to start dialysis, which means they have to get out of bed at 4 o'clock to get there in time. They can wander in approximately when they need to, give or take a half-hour or an hour.

The other major benefit I see: Not all the patients agree with me, but I believe the participation in their own care is a significant factor which improves the quality of their care. They now understand what factors are making some things improve and what factors are making some things deteriorate. As opposed to coming in one day and telling the nurse off because they've drunk too much water over the weekend, they come in realizing that it's their responsibility. I honestly believe their care is better. That's a difficult thing to prove scientifically, because obviously these patients are the healthy ones who were preselected to be good, but the patients in Belleville are stable and they're good.

1720

**Mr Wessenger:** Any idea, a rough percentage, of the type of patients you think could be dealt with at the self-treatment type of centre?

**Dr Toffelmire:** Let's define "self-treatment" just a bit. The chronic ambulatory peritoneal dialysis we're talking about is also a self-treatment, and that obviously is done outside of the hospital. If we limit our observations to the haemodialysis unit, of our total population of nearly 100 patients we have 20 patients in the self-care unit in Belleville and we have approximately 10 patients in the self-care unit in Kingston, so that's somewhere in the range of almost one third of the haemodialysis patients who can do self-care.

**Mr Wessenger:** I assume that those who would do self-care at the satellite centre could also do it at home. Would that be a fair reflection?

**Dr Toffelmire:** They would be capable of doing it themselves at home, but there are two other things: When they dialyse themselves in the self-care centre, they do have a surrounding of people for help. For example, if something goes wrong, there is somebody there, either a patient next to them or a nurse at least in the next room, who can help them out. This is going to happen from time to time. I don't think there would be very many physicians in the province yet comfortable with allowing a patient to dialyse themselves all by themselves, privately, with nobody watching over them. On many occasions



this would be safe, but on the rare occasion when it wouldn't be safe, that would be a real tragedy.

**Mrs Sullivan:** There are several issues you've raised that I'm quite interested in, one of them with respect to the ratios you've raised in your charts. You've shown Ontario with respect to dialysis comparable to Denmark, I gather. How would the transplant ratios compare to those other jurisdictions?

**Dr Toffelmire:** Certainly the transplant rates vary between countries. For example, in Japan transplant rates are relatively low. That may explain some of the discrepancy, but certainly not all of the discrepancy between the incidence and prevalence of dialysis therapy in Ontario or in Canada.

**Mrs Sullivan:** I wonder, particularly in relationship to those jurisdictions that are most comparable to ours, if in fact we do have a higher transplant rate than, say, the US as well. Perhaps someone knows that.

**Mr Wessenger:** I think it's in the graphs. It does show we do have a substantially higher transplant rate than the USA. It's 258.4 per million population in Ontario, and it's 182.2 in the USA.

**The Chair:** That's in that background document?

**Mr Wessenger:** Yes.

**Mrs Sullivan:** Somebody may want to explain the significance of that, but it seems to me that that would be significant.

You touched on the fact that the dialysis machines are not the only issue, that human resources—other people to assist the patients—and indeed medical supplies are also part of the scenario. Given that, what would you say would be the effective size for a satellite centre? What would you see as being other necessary supports within a satellite centre over and beyond the machines and the physical location?

**Dr Toffelmire:** Part of the question has to be answered by saying that there's going to be a lot of local variability. There are going to be solutions found in some localities which are preferable for that area and not in others. You're right that the cost of the machines is present, but compared to the cost of the labour and the overhead, it dwarfs considerably.

For example, if a satellite unit were present in Toronto, as it is, there doesn't need to be a doctor nearby, there doesn't need to be a number of other resources nearby, laundry facilities and that sort of thing, because it's a few miles down the road where those facilities are easily available, and if the patient in the satellite centre needs to be seen, they slip down to the main unit in Toronto.

In the more remote areas, that's a little more difficult. The patients who are dialysing in Belleville do not see physicians from one treatment to the next. We go down there on a monthly basis to review them, basically to review how they're doing, how they're complying and what their bloodwork is.

Depending on the local situation, it may be necessary for a physician to see them more or less frequently. In most centres, I understand that the patients actually are not visited by the physicians but that the patients go back to the parent site to be seen as follow-up. That's probably

a more efficient way to do it, but the patient's quality of life and quality of care might diminish a bit.

**Mrs Sullivan:** I understand that at Kingston general, there is a Rand formula, an outcomes measurement form used with dialysis patients. I don't know if it's still being used, but certainly I read a paper about it being used a couple of years ago. I wonder if you've used that in the satellite centre, or a similar patient measurement of patient satisfaction, and what kinds of responses you have received in those analyses with respect to satellite centre delivery vis-à-vis institutional delivery.

**Dr Toffelmire:** I'm surprised at the amount of up-to-date information you have. Yes, we are using the Rand measurements. I didn't know how widely that was understood. We began to use it on an experimental basis a couple of years ago. Specifically, when we knew we were sending patients to Belleville, we thought this was an ideal research opportunity, where we could see what the patients were like in terms of quality-of-life measurement before they went to Belleville, followed up by after going to Belleville.

They've only been in Belleville for six months now, and in general the quality of life is similar to that when they were in Kingston, except for a couple of the scores. For example, general health score across the board seems to have been improved coincident with their move to Belleville. Whether this is because they don't have to travel isn't clear at this point.

We've gotten a lot of information from the SF-36 questionnaire we've been sending out. We're checking most of our patients approximately every three or four months to see what sort of quality of life they have, and is there anything other than lab data we can address to help improve their quality of life? Such things as mobility aids, physiotherapy, occupational therapy, which may not immediately be obvious, are sometimes being brought to our attention by some of the responses to these questionnaires on our general population as well.

**Mrs Sullivan:** I think I'd be interested in seeing those when you're finished.

**The Chair:** Mr Wilson. I just note that Dr Mendelssohn would like to make a couple of comments, with Dr Toffelmire's indulgence. After Mr Wilson has asked his question, I'll invite Dr Mendelssohn back to the table, and indeed if there are things people want to comment while we've got everyone here, I think would be useful for the committee to take advantage of our two specialists.

**Mr Jim Wilson:** Thank you very much, Dr Toffelmire, for attending today. I know you're a very busy individual in eastern Ontario.

With respect to background information, yes, some members are very much up to date on the issue. I think a lot of the credit goes to Dr Mendelssohn and Dr Roscoe, who have kept their fax machines very busy providing us with background information, and doing it in a non-partisan way, obviously, because they're supplying everybody with it.

The highway map of the province you showed us with the clusters of patients shocked me, with your comments

about patients moving. Is that generally what the recommendation is from their local physicians, that they move? I know what happened to one of our patients. When the physician got so frustrated, he suggested to a person who now has an in-home machine: "Listen, the system can't look after you. We can't look after you. If you can't stand the drive, you'll just have to move to Toronto." I thought that was an astounding thing to have been said in the 1990s, but according to your map it seems it's quite common that that's what has to happen.

1730

**Dr Toffelmire:** Yes. The decision goes on much earlier, usually prior to starting dialysis. They realize that they are going to start dialysis and we then begin to educate them as to what options are available.

We've talked about the peritoneal dialysis and the haemodialysis and, in general, we're telling them that the influence of peritoneal dialysis on their lives is that they're going to have to do something with their catheter probably four times a day or four times a night, but it's in their own home.

If they require in-centre haemodialysis, and that means the drive, in Kingston, when you live across the street, that's not a big deal, but if you live in Bancroft, it is a big deal. You couldn't really see the colours of the dots on that map, but they were colour-coded to peritoneal dialysis and haemodialysis. Many of the dots that were farther away from Kingston were obviously patients who were on peritoneal dialysis; some of them travelled, but many were on peritoneal dialysis.

We attempt very strongly to allow the patient their choice of their modality. One of the options that we would like to provide them with is a dialysis unit in their own community, but that isn't feasible in 1989, 1990, 1994. When they have to make the decision, they have to look at what's available right now, and that basically means self-care in Belleville, move to Kingston or drive to Kingston, or peritoneal dialysis.

**Mr Jim Wilson:** I was also interested in your comments that some patients don't want haemodialysis. What happens to them if they reject dialysis treatment?

**Dr Toffelmire:** If patients have end-stage renal disease and they decide that they don't want to be dialysed, they die.

**Mr Jim Wilson:** Would it be your opinion—this may be an obvious answer; it may not be—but if they had a satellite in their own community, would it make that choice a lot easier or not?

**Dr Toffelmire:** It's hard to answer that but probably, if the facilities were closer by, some more patients would accept them. It's a little bit out of the region that we're talking about, but a couple of our patients in Moose Factory zone have decided that they really do not want to move away from their culture in order to get their haemodialysis or peritoneal dialysis, so they've stayed there and died. That hasn't been as common in the more heavily populated areas in southern Ontario but it does occur.

**Mr Jim Wilson:** That's astounding. With respect to Dr Mendelsohn's comments about a liberal intake policy,

do you share his view there that we should try and put as many people on dialysis as possible and then weed it out from there, depending on the patients?

**Dr Toffelmire:** Every patient who suffers from end-stage renal disease we know is going to die if they're not dialysed, and certainly I agree that patients who have that disease should receive the therapy of choice, it being available, so it's offered to all patients. Some patients—although I said the rare ones—the occasional patient will find that dialysis is not something that sustains the quality of life that they require and so they will stop and die, but that is a big minority. Most patients would prefer to live than to die and would prefer dialysis than not.

**The Chair:** Dr Mendelsohn, do you want to come up and join Dr Toffelmire? I think it was during Mr Wessenger's question, I could see that you had a couple of thoughts you wanted to add. To members of the committee, if there is one more question that people want to ask while we've got both of them here together, the Chair is prepared to accept those questions.

**Dr Mendelsohn:** I just thought it was important to expand on the answer about what's the correct proportion of patients who can do self-care. It varies according to the region, because of the population demographics and also because of the percentage of patients who are already doing home dialysis by the peritoneal method.

For example, in Toronto 50% of patients do home peritoneal dialysis. The provincial average is only about a third. If you have way more patients doing home peritoneal dialysis and you have the other 50% doing haemo, a smaller per cent of what's left over, if you like, can do the self-care.

What hasn't come through in the presentation so far is that in the 10 or so years from 1981 to 1992, the average age on dialysis has increased from roughly 51 to 57 years. In general, as the population ages, then they are less able to do self-care. As we move into the late 1990s, you could anticipate perhaps that the percentage who are able will decrease.

One of the things we've seen in Toronto is that in the last 10 years we actually increased the percentage of haemo because of the aging population. You can't give one formula for the whole province.

**The Chair:** Ms Sullivan, you had a question.

**Mrs Sullivan:** Yes. I wanted to just ask a supplementary to the question Mr Wilson asked with respect to people choosing not to receive dialysis at all. The assumption is, of course, if the consent or withdrawal of consent is informed, if they understand the risks and the various opportunities for treatment, that is an appropriate decision for someone to make. Would there be many instances where that decision is made in a substituted way? In other words, are you dealing with a person who is incapable of understanding frequently the full range of choice?

**Dr Toffelmire:** The scenario that you bring up is a difficult one to answer. Certainly in the Kingston area, there are no patients who have stopped dialysis without considering it in their own mind and making the choice themselves, or usually with the support of their family.



But certainly it's not been the family's decision, it's been that patient's decision.

The issue as to whether or not patients should receive dialysis when they are incapable of making choices themselves is a difficult issue and we all grapple with it.

**Mrs Sullivan:** Not solved yet.

**Dr Toffelmire:** It's certainly not solved. That's probably a social question that you're asking as opposed to a medical question. If socially we're told that patients who can't make their own decisions and patients who have substitute decision-makers who provide the decision are available, then that's a big step that we haven't taken in this province yet.

**Mrs Sullivan:** If that becomes a necessary part of the protocol, as determined by society in some way or another, presumably the cost will also increase.

**Dr Toffelmire:** The cost of providing service to the patients who decide not to dialyse?

**Mrs Sullivan:** No, where there is a substitute consent, where they may not be receiving dialysis now.

**Dr Toffelmire:** I'm not aware of any cases where the substitute consent or even a patient at the present time has decided not to receive dialysis. In most cases they are receiving dialysis.

**The Chair:** Mr Wilson, a final question.

**Mr Jim Wilson:** I just want to know, from either of you, whether it's too simple to say that most patients start on peritoneal and, as their condition deteriorates, end up on haemo.

**Dr Toffelmire:** Yes, I think that's too simple. As a physician, I would prefer to ask the patient to choose the modality that he finds most fitting with his lifestyle at the time that he's to start dialysis. If that is haemodialysis, he

should be on haemodialysis; with peritoneal dialysis, he should be on peritoneal dialysis. Certainly, as a patient goes on to one form or another, there can be problems or complications with that type of dialysis.

For example, in haemodialysis you need a fistula, which is basically an operation that joins an artery to a vein in the arm or the leg so that one of the veins is very large so you can take the large dialysis needles and put them in the vein. This fistula takes some blood away from the hand, for example, that was normally designed by our makers to go to the hand and on occasion, especially with people with vascular disease or diabetics, they don't get enough blood to the tips of their fingers and they run into difficulties there. If they have a vascular problem like that, then one of the options is to close the fistula and put them on the peritoneal dialysis.

Similarly, there are patients who are on peritoneal dialysis for an extended period of time who run into problems; for example, repeated infections or other difficulties where peritoneal dialysis becomes inadequate and therefore they have to move to haemodialysis. Any haemodialysis program requires the capacity to allow flexibility of having patients go from one to the other.

Even a transplant program, patients are not going to maintain their transplants for ever and they're eventually going to go back on a dialysis at some point and those patients must be accommodated in the dialysis unit. There has to be the flexibility of numbers in the haemodialysis and peritoneal dialysis programs to allow for this.

**The Chair:** We want to thank you both for coming today. This has been extremely helpful for the committee as we start our deliberations. Thank you again. The committee then stands adjourned until 3:30 tomorrow.

The committee adjourned at 1740.







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Third Session, 35th Parliament

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**Official Report  
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(Hansard)**

**Tuesday 12 April 1994**

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des débats  
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**Mardi 12 avril 1994**

**Standing committee on  
social development**

**Comité permanent des  
affaires sociales**

**Dialysis treatment services**

**Services de traitement par dialyse**

Chair: Charles Beer  
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## LEGISLATIVE ASSEMBLY OF ONTARIO

## ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON  
SOCIAL DEVELOPMENTCOMITÉ PERMANENT DES  
AFFAIRES SOCIALES

Tuesday 12 April 1994

Mardi 12 avril 1994

The committee met at 1534 in room 151.

## DIALYSIS TREATMENT SERVICES

Consideration of the designated matter pursuant to standing order 125, relating to dialysis treatment services.

KIDNEY FOUNDATION OF CANADA,  
GREATER ONTARIO BRANCH

**The Vice-Chair (Mr Ron Eddy):** Good afternoon, ladies and gentlemen. Welcome to the standing committee on social development, which is presently holding hearings under standing order 125, the designated matter being dialysis treatment services.

The first presentation is to be made by the Kidney Foundation of Canada, greater Ontario branch. Would the representatives come forward. Please be seated, introduce yourselves and proceed with your presentation, and we hope that at the end of your presentation there will be time for questions. Welcome to the committee.

**Ms Catherine Johnston:** Thank you, Mr Chairman and members of the committee. My name is Cathy Johnston. I'm here representing the Kidney Foundation. With me I have Janet Bick, provincial advocacy coordinator for the foundation, and Dr Bill McCready, chairperson of our Ontario medical advisory committee.

We have a written presentation, which you have in front of you. In the interests of brevity I will highlight those areas I'd like you to pay particular attention to, but encourage you to read our entire presentation at your leisure because there's information in there that I'm sure will help amplify and explain some of the things we'll be saying. I thank you again for allowing us to make a presentation to your committee, and perhaps to start, a few words about who we are.

We are a national volunteer organization and we are dedicated to improving the health and quality of life of people living with kidney disease. The Kidney Foundation funds research, provides services for those special needs of people living with kidney failure, actively promotes an awareness and commitment to organ donation and, most importantly, we advocate for access to high-quality health care. It's this final goal that brings us here today, as we believe that without a stronger commitment by the Ministry of Health to the growing crisis in the provision of dialysis services, our access to high-quality health care is in jeopardy.

I'm here as a volunteer with the Kidney Foundation. I'm chair of our government relations committee, but I think most importantly, I am one of the 5,600 people living in Ontario who are being treated for kidney failure. I am someone who relies for my life on dialysis. Without

it, I die. Without it, I wouldn't live a week. That's a fact we cannot avoid when we're talking about dialysis.

The number of patients continues to grow, every year, 8% to 10%. There's no reason to expect that will change; that has not changed in the years past. There's no cure. There are only three ways to be treated: two kinds of dialysis, or transplantation. That's it; there is no other way.

People with chronic renal failure face tremendous physical, psychosocial and financial burdens. The time invested demanded by dialysis treatments is significant and generally interferes with normal living patterns. As an example, I work full-time—I'm fortunate enough to be able to do that—but three nights a week, Monday, Wednesday, Friday, I spend four hours hooked up to a machine. That is my life. That does interfere with a normal life pattern, I'm sure you can agree.

We suffer from fatigue and a variety of other physical discomforts, we have the strain of coping with a chronic and life-threatening illness, and many others have multiple medical problems in addition to this. We have a restrictive diet, curtailment of fluid intake, and extensive drug therapy. This is all part of what we live with every day.

We face extraordinary costs related to our illness. We have to get to our treatment. Some of us need special equipment. We have medically necessary prescriptions and over-the-counter drugs not covered by hospitals, private health plans or the Ontario drug benefit program. Support services available to patients through the hospitals such as drugs, transportation subsidies, parking, meal allowances and accommodation costs for training are being continually eroded.

Living with kidney failure imposes continuing stresses on families and family members, including treatment restrictions, and financial worries and constraints. There are strains on marital relationships. We have to worry about the side-effects of drugs. If we've had a transplant, are we going to be able to keep that transplant? We live with the threat of death. And once diagnosed, we're on some kind of replacement therapy for the rest of our lives.

## 1540

The lack of a comprehensive long-term plan for dialysis and transplantation services in Ontario, combined with the steady growth of the renal failure population, decreasing transfer payments to hospitals, social contract—all of these things are placing increasing pressure on dialysis programs, and the provision of high-quality



health care for kidney failure patients is threatened.

In 1989, the previous government announced the allocation of \$23 million to expand dialysis services across Ontario, but unfortunately these allocations weren't made as part of an overall plan or with regard to future growth. We've seen the recent opening of a new regional dialysis centre in Orillia and the Sussex Centre for self-care dialysis in Mississauga. These are the last of the phase 3 proposals to become operational. Orillia is already full and has a waiting list, and the situation at the Sussex Centre is no better.

At this time, there are no plans to expand dialysis services anywhere in the province. In some parts of the province, patients can't be offered a choice between kinds of treatment because there's an overcrowding of the facilities that are there. In some instances, people are waiting longer to commence treatment than is medically recommended. They're sicker before they can begin treatment because there is no room. Transfers from one treatment to another, for good reasons, are hard to arrange.

There's an extreme difficulty in providing flexibility of schedules to accommodate employment. My employer could come and spend an hour with you and describe the difficulties of employing someone who has to work their schedule around a dialysis schedule when they can't make alternative arrangements, can't move their time no matter what because there is no flexibility, there is no room.

Children who are on dialysis are having problems being transferred to other hospitals when they're old enough to be treated in an adult program, because there is no room.

Most haemodialysis units can't accommodate visiting patients. It has become increasingly difficult, and impossible in some instances, to travel for business, to attend to family matters or family emergencies or simply to go on vacation within Ontario. I could spend another hour with you telling you about the difficulties I've had trying to receive dialysis in Ontario other than in my own home unit. To try to come to Toronto is a major problem.

In the Toronto region, some people have no choice but to spend weeks in hospital to receive treatment. That causes unnecessary disruptions to employment and family life. Patients in many parts of the province are travelling up to two hours each way, three times a week, to get to dialysis, because there's nothing closer to them.

Many hospitals are straining just to provide access. Dialysis units are full. There's no more room. And we know that the patient population is growing at a rate of 8% to 10% a year. Where are we going to put them?

These conditions aren't confined to any one particular part of the province any more. Access to dialysis treatment is under threat across Ontario. Ultimately, the cost is going to go up. As our numbers increase, as patients are waiting longer to receive treatment, that results in longer and more frequent hospital stays, more frequent medical interventions and poorer prospects for rehabilitation.

The Kidney Foundation identified the lack of long-term planning as a key concern. We addressed this by forming

a planning group with a two-year mandate that has brought together patients, nephrologists, health professionals, hospital administrators and others. This working group on renal services is trying to develop recommendations for province-wide standards of care, prevention strategies and other areas of concern. The working group conducted a comprehensive survey of all Ontario nephrology units which has revealed a wide variance in the delivery of dialysis care and provides confirmation of the need for a comprehensive province-wide plan.

We're also a member of the steering committee for the central-east dialysis planning group, a project funded by the Ministry of Health and conducted by the district health council. We're concerned, however, over the considerable delay in getting this project started. They haven't had their first meeting as yet.

While the work of the working group and the central-east dialysis planning group moves forward, the immediate needs of kidney patients across Ontario have to be met. The Ministry of Health must not use the excuse that it is waiting for the recommendations of these groups to delay decisions affecting the provision of dialysis treatment for those who need it now.

As an example, we've worked very hard together with the Toronto dialysis committee to encourage the Minister of Health to take immediate action to address the overcrowding situation in Toronto, and we're disappointed with the lack of adequate response from the minister.

The Kidney Foundation advocates for access to high-quality care for all people living with kidney disease. We support the delivery of the most efficient and effective dialysis and transplantation care for everybody who needs it. We believe this can best be accomplished in Ontario by proper planning on a regional and province-wide basis.

The population is growing, and it's the responsibility of the Ministry of Health to ensure that appropriate services are available to meet the needs of this group of Ontarians who depend on this life-saving treatment.

Advances in dialysis technology and the development of more effective drugs to prevent rejection in transplantation have made treatment for end-stage renal disease possible for most people requiring it, regardless of age or other medical conditions. Better planning and an efficient management and delivery structure will ensure high-quality care, consistency of service and a maximum return on public funds allocated to treatment.

In serving the needs of people with kidney disease, the Kidney Foundation is committed to working with the government to achieve the most efficient and effective delivery of renal care to all those who need it.

We urge the members of this committee to make strong recommendations in your report to the Legislature regarding the need for solid government commitment to long-term planning for dialysis care, as well as immediate solutions for today's crisis. People's lives will depend on it.

We'd be happy to entertain any questions.

**Mr Jim Wilson (Simcoe West):** Thank you, Ms Johnston, for coming here today along with Ms Bick and

Mr McCready. I know it was short notice. I should explain that my resolution was sort of crammed in at this point, in case the government sends this committee a piece of legislation; therefore, we wouldn't be able to debate the resolution because legislation takes precedence in terms of the committee's time. I do thank you very much for a very comprehensive brief on short notice.

Also, please take back to your board my thanks for the presence of Janet Bick. In my community, she's worked with my constituents and with the local Kidney Foundation branch, and we've been very grateful for her input. Thank you, Janet, on a personal note.

Having said that, I sense the frustration the foundation has had with this issue. The intent of these hearings is to try and promote the issue as a priority with the government, and we hope that will be the response, that the government will say, yes, we've got enough evidence now to show that not only is long-term planning needed but, as you mention in your summary remarks, immediate solutions are needed.

Before I get to the immediate solutions, though, I want to ask you about some of the history. I'm new to the issue, because constituents came to me quite a few months back and asked me to get involved. You're living with kidney failure and are a long-time member of the Kidney Foundation. The government has had lots of warning about this crisis. Why, do you think—and I want your candid opinion—is there foot-dragging on this?

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**Ms Johnston:** I think there have been some numbers games being played, arguing about whether we had a crisis or whether we didn't. Money has always been a problem, and it's hard to set priorities in the health care area where there are so many competing interests. I don't think anybody set out to purposely curtail dialysis. I think that it's just there are so many competing interests and there was a problem in establishing to the government's satisfaction that we had a problem.

**Mr Jim Wilson:** I appreciate your response, because that's been exactly my feeling. I feel when I deal with bureaucrats at the ministry and in talking privately and in the Legislature with the minister that certainly their perception up till now has been that there really isn't a crisis, that they've got other problems that are more serious.

I guess I can't understand that in terms of, as you said in your own comments this afternoon, you have no choice but to be dialysed, either that or a transplant, and transplants have plateaued. You mentioned in your brief that they've actually decreased over recent years.

We finally get this thing as at least getting the government to acknowledge the need for the central-east study, and it announced the money informally in November. I have the press release here and I talked about it prior to that, in September or October. I was under the very clear understanding that six months later or so we would have the end of that study, and you've indicated, and it's important the members know, that they haven't yet had a full-fledged meeting.

**Ms Johnston:** I think they have a meeting scheduled

for this Friday. That is their first meeting.

**Mr Jim Wilson:** Do you have any thoughts on that process? Because there was a very specific promise made by the ministry and it's just not been kept.

**Ms Johnston:** I think maybe I'll let Janet answer that, because she has more familiarity with that.

**Ms Janet Bick:** I'd like to give you a little more of a historical perspective on the central-east planning committee. The life of the central-east planning committee in fact did not begin last September, but almost two years ago this very month a first meeting was organized by the chairman of the Toronto Dialysis Committee to bring together ministry, district health council, hospital administrators, the Kidney Foundation and nephrology division heads to look for some response to a situation that we see today that was already existing at the time, two years ago. We participated in that meeting.

At a subsequent meeting in May of that year the recommendation was made that the district health councils should undertake to put together a central-east planning group. In November 1992 that group was actually put together under the auspices of the central-east DHCs with some administrative support from the Metro DHC. That group met for approximately four or five meetings between December and the end of March 1993 and then was disbanded at that time because it was felt that there were not adequate resources available to do a proper plan.

At that point they sent out letters to all the various players—the hospitals, ourselves, the Ministry of Health—asking for funding in order to hire a health planner and carry out a proper plan. We were willing to provide some funding, provided that everybody else was ready to kick in. That wasn't the case. At that point I believe they turned back to the Ministry of Health. The \$100,000 eventually was allocated last fall.

We're looking at a problem that was identified two years ago, and it is only this week that the committee will properly meet to really tackle the issues. They are meeting to tackle the long-term plan, which is clearly needed. In the interim, in the last two years, there's been absolutely no response to the immediate needs. That's the gist of it.

**Mr Jim Wilson:** That's very helpful.

**Mrs Barbara Sullivan (Halton Centre):** I was trying to give you a pink flag there, Mr Chair.

**The Vice-Chair:** Yes, I see.

**Mrs Sullivan:** First of all, let me congratulate you for the work that you have been doing. I think it is very important to have a full provincial strategic plan in terms of kidney disease that looks at the full continuum from prevention right through to patient services and including treatment. I know, from talking with other people over a period of time, that you are looking at the various modalities and at some of the issues associated, by example, with transplant, including a presumed consent option.

Do you want to discuss that at all today? I have another question, so I want to know how much time I have, Mr Chairman.

**The Vice-Chair:** You have time for the—



**Mrs Sullivan:** Do I?

**The Vice-Chair:** Yes.

**Mrs Sullivan:** Because I have another question with respect to patient services.

**Ms Bick:** The working group on renal services has looked at all the four areas of care, which are pre-dialysis, haemodialysis, peritoneal and transplantation, and we expect to have a final report at the end of this year with recommendations that we hope will be carried forward to the Ministry of Health and carried out by the ministry.

With regard to issues around organ donation and the various possibilities of increasing that, I think at this time the national level of our organization is going to be taking a very in-depth look at the problem around the lack of kidneys that are available for transplantation. In fact, we are devoting our entire national annual meeting in June to a workshoping of this particular issue, to looking at it, to looking at some of the alternatives and hopefully coming out at the end of that with some new strategies.

At this time, and I think up until this time, the Kidney Foundation has played a leadership role in promoting organ donation. The multiple organ retrieval exchange—MORE—program was originally funded by Kidney Foundation money, as were a number of organ procurement organizations across the country. In all cases they have been taken over as time went by and government funding is what drives them now.

We've also been very involved in a leadership capacity with the national and provincial organ donor coalitions. I think we've come to the point, and I think the point has been made already at these committee hearings, that the usual organ donation awareness programs and so on are just not doing the job and we are hoping to come out of our meeting in June with some new strategies that will allow us to look at ways to increase the supply of organs.

**Mrs Sullivan:** Good. Certainly the tale you tell with respect to the operation or the beginning of the operation of the central-east planning group is really quite shocking. I know that there were some questions too as to whether a nephrologist would be involved on that committee. Has that been settled?

**Ms Bick:** There are two committees. There's the steering committee and then there is the technical advisory committee, and there will be, I believe, at least two nephrologists on that technical advisory committee and that technical advisory committee will have one or two members on the steering committee. I do understand that there has been some attempt to see that there is a little more nephrology representation. I'm not sure if that's been resolved yet or not.

**Mrs Sullivan:** You certainly stress the urgency of not only an interim plan but action in terms of dialysis. Has there been a recommendation for a plan put forward from within the group, from the foundation or from the planning group?

**Ms Bick:** Again, perhaps a little bit of history on this one. As you understand, this issue has been identified as a problem for over two years. Last year, when the first

central-east attempt fell apart, the Kidney Foundation decided that it was time to look at some other strategies for bringing this problem to the attention of the minister.

We arranged a meeting last May. We met with Mary Lewis, who was the executive assistant to Mrs Grier, and brought our concerns to her. The presentation that you saw Dr Mendelsohn give yesterday, he also presented at that time. At that meeting we were promised that this would be looked at. We presented a lot of material, much along the lines of what you see in our package today, and we asked that something be done.

#### 1600

Subsequent to that, the Kidney Foundation and the Toronto Dialysis Committee organized, in June, a meeting again that brought together hospital administrators, division chiefs of the nephrology programs in the central-east area, Kidney Foundation people and ministry personnel to discuss what we can do and to provide some potential solutions. At that meeting, the hospital administrators were told that the ministry would receive and review submissions from them based on the life support formula, asking them to provide what they felt would be their projected dialysis activity for 1993-94 and that these would be considered and that they would have an answer by the end of July. Nothing happened, essentially.

In the last few weeks, it is my understanding that the ministry has taken up this particular issue a little more seriously and there have been meetings between the ministry and hospital administrators and division chiefs. Again they have asked them to submit their projected dialysis activity for the coming year, with the promise that there will be money forthcoming to cover the growth on a one-year, one-time basis, and then looking at what the central-east plan proposes beyond that point. That was my understanding.

**Mrs Sullivan:** Mr Chairman, could I ask for a response in this area from the Ministry of Health, confirmation of the continuation of the life support formula and the commitment to the attacking of the interim plan through that formula?

**The Vice-Chair:** At this time?

**Mrs Sullivan:** Yes.

**The Vice-Chair:** Can one of the parliamentary assistants—

**Mr Paul Wessinger (Simcoe Centre):** Yes, I think we have some staff who could probably answer.

**Mrs Sullivan:** We can have a written response so that we don't have to hold up the witnesses, but I'd like to see that commitment, whether in fact we're dreaming in Technicolor as to whether those life support funds are even going to continue.

**Mr Wessinger:** Yes, I've requested staff to prepare that.

**Mr Jim Wilson:** Secondly to that, it's my understanding the approach the ministry's now taking once again is stopgap. It's more of the same old stuff over and over again. I think we should ask for a firm date in writing of when the central-east dialysis study committee is to report. I think they should be forced and the ministry should be forced to adhere to a commitment.



**The Vice-Chair:** Mr Wessenger, do you wish to proceed?

**Mr Wessenger:** Yes, in my questions. I gather that you have the overall planning process with your working group on renal services. That's done on a provincial-wide basis on your general strategy, is that correct?

**Ms Bick:** Yes.

**Mr Wessenger:** The central-east planning group is on what resources are needed, basically. Is that what you see the role of that, to determine the resources that should be available in the central-east region as the result of that study?

**Ms Bick:** I've only just, in the last couple of days, actually seen their proposal and terms of reference. I haven't really had an opportunity to review them in detail, so I'm not entirely clear at this point on what exactly their mandate is. I think that the working group is looking at a much broader set of issues than central-east, both because it is province-wide but also because we are looking not only at the basic provision of treatment but all of these support services that have to go along with that.

**Mr Wessenger:** Yes, I assumed that the two studies were looking at different aspects. Is the central-east the area that has the most resource problems in the province?

**Ms Bick:** Up to this time, I think it has. We're certainly beginning to see signs of similar problems elsewhere.

**Mr Wessenger:** Thank you. I have no further questions.

**The Vice-Chair:** Thank you for your presentation. We're very pleased to have you today.

**Ms Bick:** Thank you.

WILLIAM MCCREADY

**The Vice-Chair:** The next presentation will be made by Dr William McCready of McKellar General Hospital, Thunder Bay.

**Mr Jim Wilson:** Just before the witness begins, perhaps the committee could be provided with the terms of reference, when they're available, put together by the working of the Central East Study Committee, so we can know at first hand what exactly the mandate of the committee is.

**Mr Wessenger:** I think certainly that's a reasonable request.

**The Vice-Chair:** Would you like to proceed?

**Dr William McCready:** Thank you. This is a unique opportunity for me. I'd like to compliment the committee, first of all, on having the foresight to ask someone from northern Ontario to present some views to your committee. We're frequently forgotten in many issues, but in health care especially.

The Ontario Ministry of Health faces a difficult dilemma in the provision of care to patients with renal failure. The number of such patients, as you've heard, is growing. It grew by 7.67% between 1991 and 1992, the last year for which we have final information. This growth rate is not confined to Ontario. The rate in Canada as a whole was 9.1%. Indeed Canada's renal failure rate is

still lower than that of the United States and many European countries. This may reflect a hidden form of rationing of dialysis, as it's difficult to believe that Canadian patients are really different from their counterparts to the south.

There's preliminary information from a study by our colleague which strongly suggests that family doctors and general interns are not referring all elderly patients for consideration for dialysis. Again, that's likely influenced by their knowledge of this crisis of overcrowding in our dialysis units.

The resources allocated to the management of the population of patients have not kept up with demand. You will no doubt hear of overcrowding and undertreatment in every area of the province. Even when the allocation of funding to a dialysis unit has not been reduced, the impact of health care funding cutbacks has had a profound effect on patients with kidney failure. In particular, cuts to operating room and intensive care budgets have made providing high-quality care to this group of patients, who by the nature of their illnesses are among the sickest of all, most difficult.

To be able to refer a patient with kidney failure who is unlucky enough to have another illness requiring the intensive use of health care resources such as cardiac surgery to an academic centre is now a major challenge for those of us outside the major metropolitan areas. Patients with these complex problems do not always have the highest of profiles. Due to the extreme nature of their illnesses, delay will often end in their death and the end of the problem. There are many examples of this. I'm not going to try to regale you with them, but certainly this is not a theoretical concern.

Other impacts that funding cuts have had relate largely to drugs. Changes in the Ontario Drug Benefit Act have removed a significant number of medications as eligible benefits. While many of these drugs were of questionable medical necessity in the general population, patients with kidney failure rely on these products for their continued wellbeing. A noticeable example is calcium carbonate, a nutritional supplement in the eyes of ODB, but a vital treatment in the prevention of renal bone disease for the dialysis patient.

Drugs with special funding needs because of their high costs have also recently come under threat. Erythropoietin, a drug used to treat the anemia of kidney failure, and cyclosporin, used to prevent transplant rejection, are examples. Funding freezes or rollbacks seem to have been averted for now, but only after intense lobby activity by the kidney foundation.

Proposals to include funding for these drugs in hospital global budgets and comments that delisted drugs should be paid for out of existing budgets totally ignore fiscal reality and further disadvantage our patients.

Ontario has now reached a crossroads in the provision of such sophisticated types of health care. The nephrologists of Ontario are unwilling to act as arbitrators to decide who should and who should not receive such therapies. The need and projected need for dialysis are well known and have been well discussed. The holders of health care purse-strings must indicate if our society can

no longer offer treatment to all. Physicians are inclined by temperament and training to treat those who they feel may benefit and who wish to receive treatment.

Patients over 65 years of age starting dialysis are an often-mentioned target in the public eye and the press. These patients have a 50% chance of surviving two years on dialysis. This rate is very similar to the survival rate for colon cancer in the same age group. It does not seem likely that such patients will not be eligible for surgery because of their age, and so it seems logical that age should not be a primary determinant for starting dialysis treatment.

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The growth in the number of patients requiring dialysis can be explained by a number of factors. First is the aging population. As we all age, there's an increased incidence of renal failure in older age groups. Second is our low organ donation rate. Third is our increased patient survival on dialysis because of the medical advances made, and here's our dilemma: As we get better at keeping people alive, it costs more, and the dilemma increases.

These factors seem unlikely to change, although public policy changes in the area of organ donation could potentially increase the number of organs available for transplantation. This has been addressed in detail in the past, most noticeably by a task force headed by Dr Calvin Stiller in the 1980s. A number of changes were proposed by that group but few were made.

The recent increase in organ donation rate in the province of Quebec, which followed the provision of financial payments to hospitals which identified and/or retrieved organs for transplantation, points to the fact that public policy can impact organ donation rates. It is to be noted that Canadian organ donor rates are falling behind many other countries, including the United States.

Ontario, however, does continue to treat many patients on forms of home dialysis, such as continuous ambulatory peritoneal dialysis, which are less labour-intensive for hospitals and therefore less costly. Some 47% of all new patients in 1992 started on some form of peritoneal dialysis, and at the end of that year 41.3% of all dialysis patients were on this type of therapy. It is possible that if the resources were available that this could increase a little, but unfortunately not all patients are suitable for this type of therapy.

It is also worth pointing out that while peritoneal dialysis is a very effective form of dialysis, many patients will eventually require transfer to haemodialysis, either on a temporary or permanent basis, mainly because of recurrent abdominal infection. Only 50% of patients will still be on peritoneal dialysis after four years, while more than 75% of patients starting haemodialysis will remain on that treatment. Thus we can expect more and more patients to require haemodialysis in the future, despite the growth of our home peritoneal dialysis programs.

Other methods of reducing costs in the delivery of renal failure care, such as self-care haemodialysis, assisted self-care haemodialysis and dialysis in satellite dialysis units as well as independent health facilities, are

increasing in usage, but again not all patients are suitable to receive such treatment.

Many patients across Ontario, especially in northern Ontario, are disadvantaged in their ability to access haemodialysis treatment by the distance they live from large cities. For many the choice lies between home peritoneal dialysis, a move to a larger city, or even death. I would like to emphasize, because I come from northern Ontario, that this is an issue for our native patients especially. Many of them would rather choose death than to move out of their own home community.

Frequently our patients do commute large distances for treatment, but in northern Ontario in particular these distances may be too large or the climate too unreliable in winter, to make such a choice realistic. Experience has shown that satellite dialysis not only allows patients to stay in their own communities but also greatly increases their feeling of wellbeing and hence their ability to cooperate with the complicated drug and dietary regimes necessary for successful therapy.

It thus seems clear that a comprehensive plan to deal with this problem is required. Patchwork solutions can only delay the crisis. As you have heard, the Ontario branch of the Kidney Foundation of Canada and the nephrology section of the Ontario Medical Association recognized this more than two years ago and have set up a task force with the intention of producing a report which gives an overview of the needs of renal failure patients in Ontario.

It will include recommendations concerning all aspects of renal failure management, including predialysis care, haemo- and peritoneal dialysis, transplantation and preventive measures. The challenge will be to ensure that the appropriate resources are then allocated and that future growth in the numbers of patients requiring dialysis no longer triggers the extreme overcrowding and undertreatment that we now see in many of our hospitals, not only in Toronto but province-wide.

A comprehensive revamping such as would be required will take time, and in the interim it is imperative that short-term expansion in services in areas of extreme overcrowding, such as Metro Toronto, be facilitated. Deferring such expansion until further needs assessment is done can only deepen the crisis. It seems foolish to allow the delivery of life support treatment to be driven only by budgetary forces when the delivery of such treatment should be what drives the budget.

**The Vice-Chair:** Thank you for your presentation. One question each caucus, please.

**Mrs Sullivan:** I'm interested in two things. I'm going to try to get them all in the same question to cheat the Chair. The first thing is the geographic distribution of services, where typically in northern Ontario where there is a specialized service there are problems with delivery. In fact, I was looking at the numbers of centres where dialysis is provided in the north and see that at least one of those centres is a health centre and wonder, first of all, if you could discuss the use of sites other than hospitals for delivery of dialysis in northern Ontario.

The second thing I just want to know for background



information. You and Dr Mendelssohn and the doctor from Kingston, Dr Toffelmire, have spoken really about the kinds of decisions about who will and who ought to receive dialysis. I think each one of you has indicated that you believe that's a question for society rather than for physicians themselves.

But I'm wondering if, as in the case of, by example, bone marrow transplants, there are protocols and standards that are readily definable with respect to who would be assessed and how they would be assessed on the basis of prediction of health benefit from dialysis. If there's a simple form that would explain to us neophytes how that works, ie, what the process is and what those standards are, I think that might be useful.

**Dr McCready:** To answer your first question first, I believe the health centre that you're referring to is probably in Sioux Lookout, and that's a satellite unit of my own dialysis unit. In fact the district health centre is what they call their local hospital. But there's absolutely no reason that dialysis cannot be provided outside hospital settings. We just happened to rent the space from this hospital because they had it for our unit.

I think that's certainly a very viable and cost-effective way of providing dialysis in smaller communities. You have to recognize that there's no kidney specialist in a small place like Sioux Lookout. Myself and my partner go once a month to see these patients, so they have to be stable patients who don't require a lot of medical attention. That limits what you can do.

All our patients there are native, all are doing extremely well and all are immensely happy to be there. Native patients, if you've ever met native people, are not very communicative and express their gratitude sometimes not at all, but the patients I've got there—I virtually can't go without getting a gift from one of them almost every time I see her now. It's really amazing and heart-touching to see how well they are doing.

To answer your last question, it's very difficult to predict who is going to benefit from dialysis intervention and who is not. It's pretty easy to say, if you happen to have a terminal cancer, that you really shouldn't go on dialysis, or if you're demented, you're not going to benefit. The choice of whether you start treatment really, right now in my mind, should rightly lie between the patient, the family and the physician, with the help of nurses and social workers. It's a team approach to deciding if people should start on therapy.

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Going back to my early days of training in the United Kingdom, there was a committee that decided who could start and who couldn't, and we sent 65-year-old patients home because we thought they wouldn't benefit from dialysis. I can remember sending such a patient home to die from Belfast. When I came to Canada, I met a 90-year-old lady on dialysis. She was sure benefiting and told me about the pioneer days of Canada and how she personally knew the Group of Seven. It was an amazing experience for me.

I think there are many nephrologists in Ontario who are UK-trained, and we're all absolutely opposed to the

idea of rationing dialysis based on age and other such criteria. I think if you talk to patients as well, if this is ever brought up at our government relations committee, if you mention agism or sexism or any other ism as a criterion for deciding on dialysis, you'll find our patients are very much opposed to it.

It very often requires a trial of treatment to decide if a patient is going to benefit, and if you actually look at the statistics, you'll find that one of the leading causes of death on dialysis is discontinuing treatment. That's because we frequently will try patients on therapy, find that they really are not getting along with it and then stop. And we have to have the facilities to do that.

**Mr Jim Wilson:** Thank you, Dr McCready. I think you've given us some very disturbing things to think about. It was also mentioned by Dr Mendelssohn, and we've been presented with the US situation and the statistics there. I guess it's an extrapolation of that or an overlay of that on to Canada and Ontario's population that leads to the conclusion that rationing must be occurring, rationing based on age. Do you have any anecdotal or firsthand evidence, though, that that's occurring in our province?

**Dr McCready:** Yes, it certainly is. My partner is a younger physician whose wife is an intensive care nurse who works in the hospitals in Thunder Bay that aren't connected to our dialysis unit, so we get to hear about patients who are not referred to us, frequently. I'd like to point out to you that I'm not certain if it occurs the same in the metropolitan areas, but in my dialysis unit, half the patients I see who require dialysis, I've never seen before. They haven't been referred for pre-dialysis care. They suddenly appear when there's a crisis and the family demands that there's some action. Physicians all the time say to me, "I've got this 75-year-old lady with advanced kidney failure, but you don't put patients like that on dialysis, do you?" The answer, of course, is, "Yes, we do."

**Mr Jim Wilson:** If I could just ask a supplementary: Dr Mendelssohn suggested, for example, that perhaps we should have a liberal intake policy—small-l liberal—and get everyone who needs dialysis the treatment. In your professional opinion and in your experience in our health care system, would that not save us money in the long run? If you're dealing with patients who are in crisis and then complications arise, it seems to me they would cost the system a lot more.

**Dr McCready:** It would not only save us money, it would save us lives. Patients who appear in an advanced state of kidney failure do not do as well as patients who are well prepared for dialysis. They die more. That saves you money, unfortunately, in the world of dialysis.

**Mr Jim Wilson:** It seems to be the ultimate rationing, doesn't it?

**Dr McCready:** It's the ultimate rationing is right. There's a published study which demonstrates that patients referred early for pre-dialysis care have about twice the length of survival as patients referred late. So we certainly encourage it.

**Mr Jim Wilson:** Could you provide us with that



study? Would you have that available, or direct our clerk for it?

**Dr McCready:** I can get it for you, sure.

**Mr Tony Martin (Sault Ste Marie):** Thank you very much for coming all the way down from Thunder Bay. You'll probably recognize that I also come from northern Ontario; I come from Sault Ste Marie.

I was very interested in your comments about the north and how the north so often gets left out. Certainly we as members of this Legislature make that point on a regular basis to our colleagues and friends. However, in this instance I guess I'm a little perplexed as to what we should be doing in that there were decisions made about northern Ontario by previous governments that we would regionalize our health services, Sudbury and Thunder Bay being the major regional centres, and then out of that we would, as we could afford it, provide services as they're needed in other areas.

Certainly the larger centres in the north are Thunder Bay, Sault Ste Marie, Timmins and North Bay, in my mind, and all of those centres have the resources to do the haemodialysis. Then, if you work out from there, there are smaller centres in all of the regions, places like Kenora and Sioux Lookout, which in fact you had a hand in developing as satellites. New Liskeard, Kapuskasing, Elliot Lake, Pary Sound and Little Current are all other areas that do haemodialysis in the north and offer services to the people in their area. In fact, there is a way afoot to establish three new satellites, one in New Liskeard, one in Kapuskasing and one in Elliot Lake, and also the establishment of a unit in the St Joseph's Hospital in Pary Sound and to expand what is already in Elliot Lake and Little Current on Manitoulin Island.

I know as well that in the last year or so we've introduced to the north the diabetes network that is centred in Thunder Bay and Sudbury, which is spending a significant amount of money not only among the populations that are shared by those communities but also native communities, to do some prevention work in this whole area. I'll be participating in the ribbon-cutting of a brand-new wing to the Plummer hospital in Sault Ste Marie of a renal dialysis unit there that has been developed.

My sense is we're dancing as fast as we can, given the resources and the environment which we're in, to provide as much as we can. I'm wondering what else we should be doing in the north at this time, which communities now next you would target as the ones that are most in need. And given that, as a physician, with the great demand on the medical dollar at the moment and the pressure that's on us as a government to be accountable and responsible in terms of how we spend the limited money we have—you talked about people being referred or not being referred by physicians for various and sundry, in this instance for haemodialysis, but there are all kinds of other medical needs, particularly in the north, where dollars are required to service people or send them out for specialized treatment. How do we prioritize all of that?

**Dr McCready:** That's a very difficult question for someone who's involved primarily with kidney disease patients. I would tell you I think that they're of the

highest priority, because that's my area of interest. Kidney failure patients have an unfortunate habit of dying if they don't get treated.

**Mr Martin:** So do cancer patients.

**Dr McCready:** So do cancer patients, but it takes longer. If you wait six weeks for cancer treatment, that's a big problem, but if you wait six weeks for dialysis treatment, you're dead. It's very plain.

I think that efforts have been made. I don't want you to think I feel that the Ontario governments present and past have made no efforts in this regard. I think they have and I think what's been done has been very effective. But I have several patients who live in a town called Atikokan, which is a two-hour drive from Thunder Bay on the Trans-Canada Highway, or part of the drive is on the Trans-Canada Highway. That's a very exhausting process for patients, to have to drive something like 200 kilometres either way for dialysis. I have four or five patients who live in that town.

I think that when you're looking at setting up satellite units you have to be realistic. You can't set up a satellite unit for one patient in one town. But if we could develop some criteria for the establishment of satellite dialysis units, it would include a minimum number of patients to make it viable, it would include a minimum distance from the nearest dialysis unit, and I think that can be done. One of the recommendations that will come out of this end-stage renal failure task force of the Kidney Foundation will be to set criteria for looking at the establishment of satellite dialysis units.

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The one thing I'd like to point out about establishing these—let's call them alternative ways of delivering dialysis care—is to point out to you that if you remove the stable patient from the hospital-based dialysis unit and place him in a satellite unit or a self-care unit or an Independent Health Facilities Act or wherever, what you then do is increase the acuity of the remaining patients in the dialysis unit and increase the workload without necessarily someone thinking of increasing the funding. That, I know, is a problem in Toronto, where the better patients have already moved out to satellite units and the sicker patients are in the hospital units.

I don't think you have an answer. That's the point of my presentation, that physicians can't answer that question. The physician is presented with a patient with a problem and he tries to find a solution to it. Society and the government which leads society are going to have to be the people who set these criteria and they're going to have to be up front about them so that people will know what to expect. Patients and their families expect treatment, is what I can tell you.

**Mr Martin:** Just one quick supplementary to that is, if physicians can't answer those questions such as the question of priority yet physicians are asked to make the referrals that are necessary and you're saying that referrals are screened, how do they make the decisions in those circumstances?

**Dr McCready:** I don't think physicians make decisions based on resource allocation. They don't say, "I'm

not going to send Mrs X because I know the dialysis unit's going to be crowded." They simply know the dialysis unit is very crowded and Mrs X seems a very sick old lady and they fall into the decision of not referring her. It's not a conscious thing that physicians do and it's not all physicians either.

We're trying to explain, I think, in Dr Mendelssohn's presentation and mine, why there's a gap between the US dialysis rate of something like 120 per million of new patients per year and the Canadian rate, which is now about 100. The gap is there. The patients have to be there somewhere or we believe that they are there and that they're simply not being referred and they're dying of their kidney failure.

As a nephrologist, I feel I should be going out and looking for these patients and trying to get them on dialysis, but I need the resources to be able to do that: (a) to find them and (b) to treat them when I do find them.

**The Vice-Chair:** Ms Sullivan, something urgent.

**Mrs Sullivan:** Yes, I wanted a supplementary on this particular question with respect to referral from the primary care physician.

What kinds of educational efforts are made through the OMA to the primary care physicians to provide them an indication of when referral should take place so that you are seeing the patients at the pre-dialysis stage?

**Dr McCready:** I don't believe any efforts have been made to educate the primary care physicians.

**Mrs Sullivan:** Should there be efforts made?

**Dr McCready:** Absolutely.

**The Vice-Chair:** Thank you, Dr McCready, for your presentation. We appreciate it.

While the next witness is coming forward, Mr Gardner wished to speak to his memorandum to you on technical terms.

**Dr Bob Gardner:** Members will see that I did a short memo on some of the definitions and descriptions of the various forms of dialysis treatment. This material was drawn from the background you got before the hearings, but it was buried among other things there, so I thought this might be a handy reference as we're hearing all of this stuff.

I also, of course, do want to check all of these technical terms with experts before we finally get around to writing the report, and I'll do all that before we go to press, so to speak.

**The Vice-Chair:** Thank you for that information.

DAWN EVANS

**The Vice-Chair:** The next presentation will be by Dawn Evans of the Kitchener-Waterloo Hospital.

**Ms Dawn Evans:** I'm Dawn Evans, the program manager for renal services in Kitchener-Waterloo Hospital. I would like to thank the group for inviting me to attend. Kitchener-Waterloo is in southern Ontario, but we have some very unique problems, different from Metropolitan Toronto.

I've prepared in your handout a summary of what Kitchener-Waterloo Hospital is. It is a community hospital of about 400 beds. It is the only provider of

renal services in the region. It is between London, Toronto and Hamilton, and we service a large area in between that. We are a metropolis but we serve a huge rural area, and it is not uncommon for our patients to travel one to one and a half hours each way for dialysis. Unlike Metro Toronto, there's no transit to get them there; they depend on friends and family to get there. So our location is different from some of the other larger centres. We are the only hospital that provides dialysis, so we have to look after our own. When we get crowded and overrun, we have no other hospital that can help us out within a reasonable driving distance, so we have to solve our own problems.

We are between the major centres. We refer to Toronto, London and Hamilton for tertiary care. Our patients wait for their surgery, they wait for their access repairs, they wait for medical referrals until there is a dialysis space in another referral hospital for them to be dialysed.

The pattern that has become very common for our patients lately is that they go in for surgery if it's a minor procedure such as an access revision. Because we are only a community hospital, they go into the tertiary centre for their surgery for their access in the morning, they come back in the afternoon, and they have their regularly scheduled dialysis in the evening. That's pure hell for a patient or his family member who has to transport him, because they're not ill enough to require transport by ambulance, or the timing is so tight that they can't get them back and forth. That's the impact this is having on patients.

We're also very fortunate at Kitchener-Waterloo Hospital: We have a brand-new haemodialysis unit. It was funded in 1990, and we moved into that unit in July 1992. That unit was to last us five to 10 years.

We have made some plans as we go through this process to try and prevent a crisis. We have added an assisted care dialysis unit within the hospital. It was a last-minute addition to our program to try to take some of the patients from the haemodialysis unit. We have closed down our in-hospital peritoneal dialysis unit. It was costly for a few patients and it wasn't felt to be effective for the few we were treating, so we now treat them with a different mode of dialysis.

We have increased the staffing in our CAPD unit to be able to send more patients home on that program. We have added a home cycling program to be able to give patients more options at home to be able to dialyse, especially those rural patients who have that long travel.

Those are the kinds of things we've done as we've moved into our new space and as we've lived in our new space and realized that we're going to be in a major problem very, very quickly in spite of our brand-new unit and a completely renovated floor of a hospital. Our whole program is on one floor now, which has many added benefits, but we're on the seventh floor and we can't expand out. We're going to be in a crisis in a very few years.

If we take some of the numbers that Dr McCready referred to, if we take the low end of the projected growth for dialysis patients at 10% per year, this is where



we are and this is where we're going to be in 1996. I've applied that same 10% to the transplant numbers and to the people awaiting transplants on the list, which perhaps isn't accurate, but I thought I would use that same 10% across the board.

We have a brand-new haemodialysis facility and its capacity is 96 patients. If you look at 1993-94, we did 97 dialysis patients, on average, in the last three months of this fiscal year that we've just finished. We're full. We have an assisted care unit that opened a year ago in November. Its capacity is 24. We now have 20 patients in that assisted care haemodialysis unit.

We have funding and staffing resources and operational facilities at this point in time to handle 54 CAPD patients. We're at 68 as we're heading into this next fiscal year. We're in trouble and we've got a brand-new facility, and we have nowhere else to turn to send our patients.

Our treatments, if you add that 10%, increase across the board to haemodialysis treatments, and those are both acute patients and chronic. I didn't separate them out, even though there is a major difference in the acuity and the cost to that. That's a phenomenal number of haemodialysis patients and treatments to be done in a community hospital.

What does this all mean to our patients?

I think too that we shouldn't shield the fact that we help Toronto. Even though we're full, we have little dips in our patient number when we'll dip down to 88, 89, 90, and we do accept patients from Toronto hospitals, primarily from the west end, Mississauga. Credit Valley in particular refers us patients to help them out of their bind. Last year we did 10 patients, for up to three months per patient, to dialyse them in Kitchener-Waterloo. Those patients travelled from Mississauga to Kitchener and back again three times a week for treatment because there was no space in Mississauga. What happened for the three months over October, November and December was that we would send back the patient who had been with us the longest and they sent a new one to replace that patient.

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Our physicians constantly liaised with that hospital to try and get those patients back home, because we, as the providers of dialysis in Kitchener, were constantly being asked, "When can I go home?" We were helping out, but we were put in a bind at the same time, trying to help that patient. That isn't right. We shouldn't have patients travelling an hour and a half from city to city to have dialysis.

This is not a patient disease; it is a family disease. When a patient has dialysis many things change for this patient and the family dynamics. When we have no place in Ontario for a patient to go for dialysis, that patient does not go on a holiday. I won't negate Camp Dorset in Ontario—it's an incredibly wonderful place for our patients—but it's become the only place they can go for a dialysis. When there is a family funeral, when there is a wedding, when there's a new grandchild, these people are unable to travel, like you and I, to attend these major social functions in their shortened life. That's not right.

They have delays in surgery, and I alluded to that earlier. When they start dialysis, there's no choice in when they will have their dialysis time. They're given whatever time there is to be put on dialysis. We make desperate attempts to work around the workers and give them priority times, but we have people squeezed into spaces that shouldn't be times for dialysis, but that's where they are because that's the only space.

I haven't been here to hear the other witnesses, but something that needs to be stated very loud and clear is the dedication of the nephrologists, the social workers and the nurses in this profession; it's absolutely incredible. They get these patients dialysed wherever they can do it, or I think we'd be in a worse situation than we are.

The waiting list for transplant: If you take those numbers I provided for you and just move those across, one in three patients on our waiting list was able to get a transplant in 1990. That increases every year as the number of patients on dialysis and therefore the number on the list and the wait time increases.

Those are the implications to the citizens of Kitchener-Waterloo Hospital's dialysis program. We certainly service a large number of patients from other areas as well, but that's the impact it has on us in southern Ontario. In my opinion it's not all that different from northern Ontario, but people don't think of us as northern Ontario. In that aspect we're very unique, I believe, in some of our problems. We're full, and that's two years after a brand-new unit and in spite of what we think are some rather heroic ways to try and live within the annual cuts we've been given, to provide service to more patients with fewer dollars every year. Thank you.

**Ms Jenny Carter (Peterborough):** It's certainly apparent from everything we've heard and from what I've heard as a member in my own riding of Peterborough too that we do have a problem here.

There are one or two things I'd like a little enlightenment on. The previous presenter did mention a woman of 90 who was on dialysis. I was just wondering, how many people over 65 would be on dialysis, what sort of percentage of the recipients?

**Ms Evans:** I would guess up to a quarter.

**Ms Carter:** So there's really no limit. I mean, people can benefit from this and achieve a much improved lifespan up to any age limit.

**Ms Evans:** Definitely, and these patients learn to do their own dialysis at home just as well as the younger people do. They do very, very well.

**Ms Carter:** We've heard repeatedly about this roughly 10% increase a year that's happening in the number of people now. I wonder whether any studies have been done to see how long into the future this is liable to continue. I can't see that we could have a 10% increase year over year indefinitely. Would you know anything about the projections?

**Ms Evans:** I don't know about any studies, but I know that Canada has one of the lowest rates per million population of people on dialysis.

**Ms Carter:** I'm just wondering whether there are any projections.



**Ms Evans:** I think the projections are that as the diabetics live longer with better treatment and as this baby boom generation comes to age, it will be a worse problem than it is today.

**Ms Carter:** So we've really got two things: We've got to do something in the present and immediate future, and we have to have plans for the long term as to how we're going to cope with this.

In Peterborough we don't have facilities. People travel mainly, I think, to Oshawa. Of course there are people in lots of different situations, and I've really been struck by the variety of situations people who need dialysis are in. Quite a few of them are managing at home and they have worries such as, "What if my mother, who is helping me out, gets too old to do it?"—that kind of thing. People have suggested that it would be better if those machines that are being used by one person could somehow be centralized and maybe nurses could be available to help people use them, and so on.

But we did hear yesterday that it is actually cheaper, a better return on the dollar, for somebody to actually have this machine in their own home, because the overheads are smaller and there aren't the labour costs.

I just wondered if you could give us some idea of what you would see as the structure of an improved system for dialysis: How much would be hospital, how much would be centres where people could help themselves, how much would be in the home—what kind of system we ought to be looking at?

**Ms Evans:** We're not funded as a home dialysis program for haemodialysis, so I can't speak to that particular mode of dialysis for Kitchener-Waterloo Hospital. What our focus has been and what we're planning with our operational strategic plan is to increase our home peritoneal program so that hopefully it could be 50% of our patient population. Whether that's realistic in the long term—because as Dr McCready said, these patients fail on peritoneal dialysis and go on to haemo. If we could have that 50%, if we could have 10% of our patients doing assisted haemodialysis and the remaining 40% requiring in-centre haemodialysis total care, that would certainly make our picture a lot brighter.

**Mr Jim Wilson:** Thank you, Ms Evans, for your presentation. I too wanted to ask a little about in-home haemodialysis, but you've already answered that you're not funded.

One of the things I've heard in the months working on this issue is that it seems to me that within the ministry there's somewhat of an argument going on about: (1) I've heard of hospitals being reluctant to take on dialysis programs, and (2) the costs associated with in-hospital care and the argument about whether it's just too expensive to be adding these programs to hospitals, that perhaps we should be looking at satellites.

You're in a hospital, you're the coordinator of the program. Could you just give us your comments on the services you're providing and whether you think you're cost-effective? This thing, unfortunately, in spite of the lives that are being lost, is boiling down, as so many issues do in this day and age, to money and priorities.

**Ms Evans:** It's interesting that as I was leaving to come here today I had someone from Guelph General administration call me to see about setting up a haemodialysis satellite program there to service the community of Guelph. So hospitals and citizens in other centres are looking to how they can have this service within their hospital.

There's no question that it's an expensive service, but we do everything we can do within the program and with our social workers and our pharmacists, nephrologists and nurses to keep these people employed, to give them the supports they can get with the least amount of cost to the system. Yes, it's expensive, but it's a really hard thing to measure. How do you measure a quality life? Most of these people would not deny that they're having quality lives and are grateful for the service they receive. How do you put a price on that? Yes, it's expensive, but can you put a price on that? I can't.

**Mr Jim Wilson:** Agreed. Just as a supplementary, have you heard any arguments—I mean, I haven't had any hospitals tell me they're opposed to setting up satellites, whether they be in independent health facilities or whatever, to actually take the pressure off the local hospital. For instance, in K-W, would that be something your board administration would agree to, for example, do you think?

**Ms Evans:** We've decided we will certainly start to look into it with the Guelph General so it can go to the ministry to see whether the ministry would agree to that as a feasible project.

We have had a satellite peritoneal unit in the Walkerton general hospital in the intensive care unit, where they looked after patients from Walkerton who were in our program; they looked after them there. We set up a satellite peritoneal CAPD program in Freeport chronic hospital. They came to us and said, "We'd like to service this patient population." So community hospitals and other hospitals work together to address this need. We do what we can with the community resources, the VON and the other home care resources, to keep the patients home without bringing them into hospital. I think, as a group of people, nephrology workers do that exceptionally well.

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**Mrs Sullivan:** Could you estimate for us the proportion of your patients who would be outside of the normal catchment area of the hospital?

**Ms Evans:** In the Waterloo region?

**Mrs Sullivan:** Yes.

**Ms Evans:** Probably 35%.

**Mrs Sullivan:** I know that in my community some people would go on to Kitchener, but most of the people from Halton would be treated in the Hamilton area, or possibly at Credit Valley, but I think Credit Valley is pretty jammed these days.

What kind of a network is there that allows you to know, or is there one, where and if there is a space available within a reasonable distance or opportunity for the patient to be served there?

**Ms Evans:** We just call each other. Manager calls manager, nephrologist calls nephrologist and says: "We

have a person who needs treatment. Can you take him?"

**Mrs Sullivan:** So it's informal and day to day?

**Ms Evans:** Yes.

**Mrs Sullivan:** I also wanted to ask what other kinds of services are provided through the hospital, including such things as social work, pastoral care and where and how the community hospital links into, say, the services that are offered through the Kidney Foundation, where the hospital would leave off and the Kidney Foundation or other community services would take over, including in-home support services.

**Ms Evans:** We have a nephrology social worker, dietitian and pharmacist as part of our team and they are full-time for nephrology. Those three people work with a nephrologist and the nursing staff to refer people to the community resources as they are being discharged. Our social worker also is on the board for the Kidney Foundation, so she has a very strong link to know the patient services provided by the Kidney Foundation and those provided by the community. She's our link to the Kidney Foundation primarily for those types of services for the patients.

**Mrs Sullivan:** Is the discharge planner for dialysis the same discharge planner as exists for the rest of the hospital?

**Ms Evans:** It's any one of them.

**Mrs Sullivan:** Okay.

**The Vice-Chair:** Thank you for your presentation.

SCARBOROUGH RENAL DIALYSIS WORKING GROUP

**The Vice-Chair:** The next presentation will be by the Scarborough Renal Dialysis Working Group. Would you like to come forward please.

Welcome to the committee. Please introduce yourselves and proceed with your presentation and hopefully there'll be time for questions following the presentation.

**Dr Robert Ting:** I'll start the discussion. I am Dr Ting. I am a staff nephrologist at Scarborough General Hospital. With me are Dr Berry, who is a nephrologist at the Centenary Health Centre in Scarborough; Keith Spiegelberg, who is the executive vice-president of finance at our hospital, who can address questions in terms of the perspective from an administrative point of view. We brought one of our patients in hospital right now, Jagsarran Beechan, who is a consumer, and he can tell you the saga of what it's like to go into end-stage renal failure as a patient in Scarborough right now; and Mary Ann Kneeland, who is the nursing manager of our renal floor at the Scarborough General Hospital. She can address any questions you have in terms of nursing care.

Right now in Scarborough we have a population of over half a million people and we have no long-term renal dialysis facilities. We are totally dependent on transferring our patients to either the downtown teaching hospitals—Wellesley, St Mike's and Toronto General Hospital—or on occasion we can send some patients out to Oshawa General, which serves primarily the Durham region but we have sent a few patients out there.

I've been in the States for the last few years. I just finished my training at Stanford University back in

November 1993, so I've only come back to the system within the last few months. I can tell you, having gone from one system and seen another, things were bad before I left, but they've gotten much worse since I've come back.

If you were a patient in Palo Alto and you went into renal failure, you would basically come into hospital and you would get started on haemodialysis or peritoneal dialysis—in most instances haemodialysis, because it's economically more remunerative for nephrologists in the United States, but either way you would get on right away. Basically the spots are there waiting for the patients, not the patients chasing the spots here.

I can speak for what happens right now to someone who goes into renal failure in Scarborough. If they come to see me in my office, basically I try to keep them out of the hospital as long as possible, which is often not in the best interests of the patients. Really, when people go into renal failure, it's much better for them to start dialysis while they're still healthy and to avoid waiting as long as possible, because you want someone who's strong so they can tolerate their dialysis well.

What we do now, though, because of the dialysis crisis, we try to put people off dialysis, try to keep them off and try to manage them medically as best we can. When they do get bad enough—either they're in pulmonary edema, they can't breathe, they're having chest pain or they're on the brink of death—we do bring them in the hospital.

When we were coming down today, I was showing David Mendelsohn's article to Jagsarran. He's actually right now on peritoneal dialysis at the Scarborough General Hospital and he asked me, "How come you never mentioned anything about haemodialysis to me before I started on dialysis?" I said: "I didn't even mention it to you because there's no way I could offer it to you. There was really no point in me offering you something that wasn't available to you."

What happens right now, when I admit patients to the Scarborough General Hospital, they get their PD catheter in immediately and they commence peritoneal dialysis, but our problem is we have no PD training program. So it's not unusual for our patients to sit in hospital for three months, sometimes four months, sometimes even longer until they get a peritoneal dialysis training spot at one of the downtown teaching hospitals. We do send some patients out to Oshawa as well for peritoneal dialysis training, but as of January 1994, they had hit their quota for the year up until March 31, so we were told they couldn't train any new people until after April 1.

I think I'm going to turn the floor over to Jagsarran and he can tell you a bit about what he's been through. I've known him since I came back at the end of November. He's still in the hospital right now waiting for a training program. He's been in the system since the end of November now and he can tell you a bit about what he's been through the last little while.

**Mr Jagsarran Beechan:** I was on dialysis in February when I was at the Scarborough General Hospital. I was waiting to go to Wellesley Hospital for training. I went there and they said they were going to call me back,



and up to now I'm waiting. I have to take the bus to and from the hospital six days a week. I have nobody to take me and bring me. I'm not working presently now, and every time I take the bus, I have to put \$2 aside. I want to know when I'm going to get training. Why can't I get training at Scarborough General Hospital and not go to Wellesley Hospital? It's not nice to go in the cold weather to and from the hospital. I would like to know if they're going to train me at Scarborough General Hospital, yes or no.

**Dr Ting:** Do you want to tell them how you felt before dialysis and after dialysis?

**Mr Beechan:** I'm a changed person now since I have this dialysis. Before, I could not eat. I was short of breath. Every week I had to go to Dr Ting's office and ask him when he was going to send me to the hospital: "I can't breathe. I can't eat. I have burning in my eyes." He said there is no place in the hospital for dialysis. He said, "You'll have to wait until the last stage." I was in a dying stage before they got me in the hospital.

It's not for me alone; there's lots of patients there, I know.

**1700**

**Dr Ting:** Right now, we have on our floor, tower eight, 38 beds. Of the 38 beds, about 10 to 11 beds are occupied by patients who really don't need to be in hospital. They're just sitting there to get their peritoneal dialysis done by the nurses because they haven't been trained to get it done yet. Now, I can tell you at Oshawa General, when they do the training, if someone is young, competent and alert like Jagsarran, it would take them less than two days to train this person to do their own dialysis to go home. But here we have young people who are perfectly willing and wanting, but there's a bottleneck in the system. There are no training spots.

So basically you have young people sitting in hospital waiting and waiting and waiting, and I can't think of a more inefficient way of using health care dollars than filling up hospital beds with people waiting to get peritoneal dialysis training.

**Dr W. Berry:** I would like to reiterate what Dr Ting has said. I've been in Scarborough since 1972 and up until about three years ago I could get my patients downtown without too much of a problem. But over the past three years, the number of patients that I have had to do peritoneal dialysis on has doubled each year. In 1991 I did 10, in 1992 I did 20—some-odd and in 1993 I did over 30. Now, these are not elective dialysis.

As Dr Ting has told you, we try to baby the patient along until we can get them into the program downtown, but when the program downtown is full and these patients can't be moved and you have somebody with shortness of breath, inflammation of the lining around the heart, can't eat, we have to bring them in and start peritoneal dialysis. And as you've heard, it can take 10 to 12 weeks, sometimes longer—14 weeks—to get patients downtown. Meanwhile, they're occupying an active-care bed.

Again, we are not funded for dialysis. We don't have the funding for the training program. We have the staff; we have the space; we could do it. I think basically the

two hospitals are virtually the same in their needs. In Scarborough, Scarborough Grace Hospital is also running into problems. In Scarborough, the Scarborough hospitals group have gotten together and we're united in trying to form a regional centre so that all three hospitals can utilize the facilities and have cooperation among the medical staff.

**The Vice-Chair:** Questions?

**Mrs Sullivan:** I'm interested in the proposal that you have put before us with respect to a centre for dialysis that would in fact be a system within the Scarborough geographic region. I wonder, first of all, if you could tell us where that is in the system: Has it gone through the district health council and so on; where is it in the process; has it gone through the boards of each of the participating groups and so on?

The second question that I want to ask is to Mr Spiegelberg, and that is what the impact is on the annual operating costs of the hospital of maintaining CAPD patients in-house, in hospital, rather than being able to put them on a dialysis program. Have you done a life-cycle or cost-efficiency analysis with respect to that?

**Mr Keith Spiegelberg:** With respect to perhaps your first question, the three acute care hospitals in Scarborough, through this working committee, have agreed on various methods of attempting to provide end-stage renal dialysis treatment to our patients. There is agreement by all three hospitals as to how to proceed, which is really quite remarkable, actually—

**Mrs Sullivan:** It's a first step.

**Mr Spiegelberg:** —and entirely due to the cooperation of the medical staff.

With respect to Scarborough General, you have to understand we do not have an approved dialysis program. We have no Ministry of Health approval for the program. We simply don't know what else to do with patients; 10 beds, to us, on that unit is anywhere from \$350,000 to \$500,000.

**Mrs Sullivan:** Have the hospitals, as a group, taken the proposal to the district health council, and where has the DHC gone with it?

**Mr Spiegelberg:** The proposal has not gone to the DHC at this point. The proposal has gone forward to a committee looking at dialysis services in the east end, but the proposal has not gone to the DHC.

**Mrs Sullivan:** I guess then the PA to the minister should respond: Since we have special-purpose bodies that are in fact looking at the urgent issues in dialysis, is the minister also going to require a re-review by a district health council if recommendations are coming forward?

**The Vice-Chair:** Would you like to address that question at this time to the parliamentary assistant?

**Mrs Sullivan:** To the parliamentary assistant. He looks as if he's going to kill me.

**The Vice-Chair:** Mr Wessinger, do you wish to respond at this time?

**Mr Wessinger:** I don't think I'm going to be able to answer the question at this time obviously, but certainly, just for clarification, if I just have a supplemental on this.



What I'm astounded at is that it obviously would be much more cost-effective for you to have a peritoneal dialysis training program in the Scarborough hospital rather than keeping people in hospital. Is that correct?

**Mr Spiegelberg:** Yes, it would be.

**Mr Wessenger:** It would be much more cost-effective for it, I guess.

**Mr Spiegelberg:** Yes.

**Mr Wessenger:** You require approval for establishing such a program. I'm just thinking in the short run as distinct from a longer term here.

**Mr Spiegelberg:** Yes, you see, in-hospital patients—we can shut down the program. We can treat patients in acute renal failure as required and then simply put them in a taxi and give them a chit to go downtown someplace, but we've opted not to do that. When we start a program, we would prefer to start a complete program that addresses all the concerns of the patient and allows us to provide for that patient on an ongoing basis, and we would need approval for a permanent program.

**Mr Wessenger:** You certainly have raised a very interesting point. I can see a need in this area for some of the—it doesn't make any sense what you're doing now, in the sense of keeping people in hospital when they could receive training quickly and be able to do their own self-help dialysis by themselves. It would make much more sense as I can see that, but I'd just like to follow that up too.

There's another issue that was raised that I would like some comment on, and that is the fact that the patients often have no choice. The only choice they're given is peritoneal dialysis. Just from a medical perspective, would you say that more patients are receiving this type of dialysis than ought to receive it? Should there be more patients who ought to be on the non-peritoneal dialysis?

**Dr Berry:** I think there are far too many patients receiving peritoneal dialysis than should be. Many of them should be on haemodialysis, but when you don't have haemo available and you've got a life-threatening situation, you have to make do with what you have.

**Mr Wessenger:** Right, and certainly in your area, that's your observation. Fine.

**Mr Jim Wilson:** Thank you for your presentation. There are just a couple of quick questions. One is to Mr Spiegelberg. I'm sorry I just sort of missed the figure. It's \$450,00 or something.

**Mr Spiegelberg:** It would be \$350,000 to \$500,000, yes.

**Mr Jim Wilson:** And you're just taking that out of global budget?

**Mr Spiegelberg:** That is correct.

**Mr Jim Wilson:** And no special funding for dialysis from the Ministry of Health?

**Mr Spiegelberg:** That is correct.

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**Mr Jim Wilson:** I'd be tempted to ask you what had to suffer in the hospital in order to be able to provide peritoneal dialysis, but I won't do that. The decision came, though, if I understand correctly, because there was

no sense referring to the Toronto teaching hospitals because of the backlog there, and you were just forced to deal with it. Is that right?

**Dr Ting:** I think they have such a backlog they can't even handle their own patients, and in a way it's even harder for us now because they're very tight. When they know there are patients on peritoneal dialysis at Scarborough General, our patients are sort of given very, very low priority because they are no longer in a life-threatening situation. They go to the bottom of the list because they're already on dialysis. Yes, they're in hospital and they can't lead a productive life, but they're in hospital and they're being kept alive. So obviously, if there's someone who isn't on dialysis yet, they'll jump ahead of our patients who are waiting for the spots downtown.

**Mr Jim Wilson:** To me, at least from my perspective, establishing a training program shouldn't be such a big deal and to me it wouldn't seem to cost that much money. Does Mr Spiegelberg or anyone else have a comment on why you haven't been able to do that to date or why the ministry hasn't responded?

**Dr Ting:** Can I just say something? I think one of the problems with dialysis you have to remember is you really have to be a complete program. You have to offer the whole complement of both renal and peritoneal dialysis really, because patients on peritoneal dialysis can develop peritonitis, they can develop complications from their peritoneal dialysis. If you have a peritoneal dialysis program without a backup system for haemodialysis, every time you had any complication in your peritoneal dialysis patients, you would be in a real—you really do need the both together.

**Mr Jim Wilson:** The last question, Mr Chairman, if you don't mind. In Markham in January an independent health facility, a private operation, was opened and it's serving 12 patients. It seems you to me you could use one in your area. Are you wedded to the idea that dialysis service has to be hospital based, or if this committee recommended the satellites and forms of independent health facilities where feasible, would you be happy with that?

**Dr Ting:** I think the Markham dialysis is probably the way to go but I think you do need a hospital-based patient because as patients are started on dialysis initially, you don't know how stable they are. I can tell you at first hand, because I cover the Markham clinic—I'm in a group and my partner's actually the medical director of the Markham clinic. We've had to turn a lot of patients in the Markham clinic away, back to the hospitals whence they came, because they're not staffed in a place like that for patients who are the least bit unstable. You really need to have a base hospital where you can send patients if they develop complications and problems.

I think you could have a smaller hospital-based program, but you probably would still need that as a backup because when you have satellite units, patients develop bleeding or they develop seizures or they develop some sort of complication related to their dialysis. They really need dialysis but within a general hospital that's able to look after them.

**Mr Jim Wilson:** That's very helpful. Thank you.

**The Vice-Chair:** Thank you for your presentation.

DIALYSIS MANAGEMENT CLINICS INC

**The Vice-Chair:** The next presentation will be made by representatives of Dialysis Management Clinics Inc, and that will include, as I understand it, Mr Noel Egguera, who is listed. Welcome. Please introduce yourselves and proceed with your presentation.

**Mr Igal Holtzer:** Thank you, Mr Chairman. My name is Igal Holtzer from the dialysis clinic in Markham. We'd like to thank you for the opportunity for doing a presentation here.

With me I have Franca Tantalo, our chief executive officer. She's a nurse and she's been in dialysis for over 25 years, so she's got a lot of expertise. Recently—we're very excited—she's leaving her current job and she's going to join us full-time to manage the clinic.

Also here is my wife, Carol. She's been in dialysis for many years. She's the president of the company. I report to her. She's been in dialysis for around 20 years. Her main role is in quality assurance, and presently she's got a full-time job at the Sheppard Centre. I'm sure you've heard of the Sheppard Centre dialysis unit. She also has two kids and me, so she's a pretty busy girl keeping the two clinics running.

Also we have Noel, who's one of our patients. We've heard that there are very few patients coming to talk here, so we asked him to come here. We appreciate he took the time to be here.

I just have 10 slides. The main objective here is basically to tell you what is the difference between what we do versus the rest of what you've heard so far.

A little background on the dialysis clinic, which I call DMC. We are a free-standing haemodialysis clinic, which means we are not a satellite unit and we are not a self-care dialysis unit. We are providing a very innovative approach to health care and very much leadership, which coexists with what the Minister of Health is looking for at this time.

We are the first and only haemodialysis unit in Canada. We've been operating for 12 years. We're an Ontario corporation. There are three partners, the three of us, 33% each, and the innovative part over here is that nurses provide the services. We do not prescribe the treatment, as Dr Ting said. Dr Tam is our medical director and he's not a partner there.

Our mission statement when we started in 1982 was to provide haemodialysis for travellers. We started in 1982 with four dialysis machines and 500 square feet, so it's very small. We were open only by appointment, so it was very expensive. But we addressed the issue of travellers, because nobody could have taken travellers in this city, so that's what we did.

All our nurses are very highly qualified nurses. They've been in dialysis for five years, and that's why we have very high-quality care there. We dialyse hundreds of patients through the year, through the 12 years, always with success. Some of those patients are being refused by Carol and Franca. They have their criteria.

We dialyse some Ontario patients, some renegades like Cathy Johnston. She was fighting that if she's allowed to travel around the world, she should have the right to travel in Ontario. She was fighting very hard, together with the kidney foundation, to be able to do that. That's why we're here today, so I'd like to thank her for that.

Some of the trends that we saw through the 1980s, I don't really want to go over it again because you heard about a lot of trends recently, just a couple of things that we came across through the years. One is the transfer of patients from one centre to another.

We got, through the years, a lot of phone calls from patients saying, "Why do I have to be transferred to Kingston to be dialysed when there's a unit here in Toronto standing empty?" We fought for that through the years, and I think now we're at a stage where we can see that a lot of people want to have this service in their own community.

In 1992, because of all those trends, we changed our mission statement. We wanted to provide haemodialysis services to patients in their community maintaining outstanding quality care in a cost-effective manner.

The Minister of Health presently, actually on December 1, granted funding for us for 36 dialyses per week, but I have to say, since we're a private corporation, we are personally responsible for that to the bank. We are servicing 11 chronic patients and one spot is always open for travellers.

Just to give you a little frame of reference from the point of view of costing, at the same time I got a letter from Jim Wilson, a letter that was addressed to you by the Ministry of Health, the funding for Orillia. For this kind of amount of money, we could've opened one unit in Peterborough, one in Scarborough and one in Alliston, with 12 patients each. That's what we could've done. And keep in mind that operating three dialysis units is more expensive than doing just one.

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Under the IHF, we got granted the licence on December 1. On December 1 we were working. We used the old clinic, to start working there, and then we moved down the hall to a new location, all new plumbing and everything, within 30 days. Everybody was pretty impressed that we managed to do it so fast. Within 60 days we were at full capacity. Now we have five patients on a waiting list, but we could have more. We just basically cut it off. You can ask Carol and Franca more about that. We really appreciate the doctors' support and the Kidney Foundation in this area.

The one thing you probably can see here is that we really have the true cost. When I submitted a proposal for expansion of our clinic to the district health council, I was told, just like I was told a couple of days ago here, that the cost of running this kind of operation in a hospital is about \$50,000 per patient per year. I put the little charts to show you.

Another thing that's very important here, and I'm urging the committee to look into this, is that when we talk cost—we're a private business. I'm counting here even the cost of the cheques in the bank, the 70 cents we



pay to the bank. We're counting the insurance, everything. In a hospital, I was told, they don't count the global budget of the hospital; they're counting it differently. So when you look into it, please look at it very carefully.

Basically, for the expansion we propose, it's approximately half of the cost of doing it in the hospital. With the new DMC, you can see there's a substantial saving there. I'm not trying to cut down the hospitals over here. The hospitals are playing a very important role in what we're doing here. We need the hospitals, as was said today here a number of times. The thing is, we can implement it faster, we can cut the bureaucracy, and we're doing a lot of high-tech stuff in there. We have very specific patients we can get in there.

I don't want to say anything about the patient comments, because Noel is going to talk about this, except that only two weeks ago a patient told me—actually a patient from Kingston, the last one; she used to be a nurse—told me that these kind of facilities are 10 times better than being in the hospital in chronic care.

In conclusion, we believe our clients or our patients should not be required to be in acute care in a hospital. They should be in their own community or closer to home. DMC can provide those services in a cost-effective way and we will eliminate some of the bureaucracy by doing so. We believe very strongly that we have the same goal as the Ministry of Health by providing this kind of progressive thinking in the 1990s.

For an action plan, on my last slide, we really have to do something about the district health council. We submitted a proposal there six weeks ago. I was told we're supposed to get an answer in two weeks. It's been eight weeks. I don't have to say any more; a lot of people said things.

Today, we can accept four more patients—today. We have the facilities to accept four more patients. We have the facilities to accept another four patients in 30 days, but we have to get the funding. You can see that it is very reasonable funding. We would like to open more facilities. We can open in Peterborough, we can open in Scarborough, the same way we opened in Markham. We would be glad to do Alliston too, providing everybody agreed to that.

We urge the committee to look into the true cost of dialysis. You should look at the types of patients that can come to us.

Also, in closing, we would like to invite the committee to our open house, which is on April 28, from 6 to 8 o'clock in the evening. You can come and see. There's going to be wine and cheese and a few other things, so you're invited to come along. Thank you for your time.

**The Vice-Chair:** Thank you for your presentation. Would Mr Egguera wish to make any statement now before we go into questions?

**Mr Noel Egguera:** I would just like to reiterate that I used to be in the hospital. I started my dialysis in 1991. I stayed over a year. When I heard that they were opening a centre practically near my place, I grabbed the opportunity. I believe the hospital is for less stable

patients. Stable patients don't need to be in the hospital. In my case, I felt better in the centre, and I have more say about my treatment. That's it.

**Mr Jim Wilson:** Thank you very much, all of you, for coming. I want to extend to Mr and Mrs Holtzer a personal thank you for your assistance and for the tour of your facility. I'd like you to describe, for those people who may not come to the open house and have not visited your facility in Markham, what it's like and where it's located.

**Mrs Carol Holtzer:** We're located at Market Village, which is a one-storey shopping mall right behind Cullen Country Barns. It provides patients with ample free parking, which is one area that patients coming to Markham have actually saved on. Right, Noel?

**Mr Egguera:** Yes.

**Mrs Carol Holtzer:** Patients aren't reimbursed for their parking three times a week in the downtown hospitals. There may be some social assistance there, but where we are, you drive in, you park, you come for your treatment. The patients are very comfortable. If they are travellers from out of town, their families can actually entertain themselves for the three to four hours that the patient is on the treatment.

We have three active haemodialysis stations. One nurse provides the treatment for the three patients, and we have a technical dialysis assistant. So there are always two people on duty at all times.

Located in our facility is also an emergency call button. One push of the button, the security at Market Village phones the ambulance and is prepared at the front door to direct them to where we are. We've used the button once, with great success.

**Mr Jim Wilson:** Perhaps just so we get our terminology right, when I referred to satellites in my motion before the Legislature on December 9, I want you to know and I want everyone paying attention to these hearings to know that I've tried to use that term in the broadest sense. I note in your presentation that you want to make it clear that you're not a satellite of some other unit, that you are truly an independent facility. However, in my terminology, I rule you into the mix—I just want people to understand that—and it's just part of the mix, because you've been quite forthright in saying that unstable patients are not appropriate.

Obviously, if you're looking for expansion, you've got demand. Can you give us some feel for how much of the dialysis problem you can look after through independent facilities? Carol, you've been in the business for many, many years as a nurse. I need a rough feel. Could 60% of patients out there go this way?

**Mrs Carol Holtzer:** No, I don't think it's that high. It's very difficult, because a lot of patients on perineal dialysis could possibly be on haemodialysis and be part of that stable population if the facilities were available for them.

It would be very difficult to actually say what that number is, because patients first going on dialysis are not necessarily stable. Once they have been on dialysis for a while and realize that it's not as frightening as they

originally thought it was going to be, then a lot of them can come out of the hospitals and dialyse in an out-of-hospital setting and feel very comfortable in that setting. But it takes a while for them to be able to get away from having all of this excess personnel around them and this hustle and bustle. It's a security issue for a lot of patients, and it depends on the individual how long it takes them to feel that way.

Our oldest patient in the clinic is 82 years old and he's absolutely delighted to be there, because it makes it very easy for him, to be able to come there. He should be able to come there for a very long time because he's very well otherwise. So it really isn't age-dependent. It really depends on the medical condition of the patient.

We're very selective in those patients. We have sent patients back, without a doubt, if we feel they are unstable or that they will become unstable, for various reasons. Physicians have been absolutely wonderful about taking the patients back and are screening the patients better for that.

But to say exactly how many patients there are, I'm not positive; maybe 25%.

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**Mr Jim Wilson:** Perhaps I'll try the question from a different angle. To make an independent facility such as yours feasible, how many patients do you require to service? The way I look at you, you could be set up in any town. Do you have a magic number, though, that makes it feasible?

**Mr Igal Holtzer:** You really should have 12. Actually, you should have probably 15 as a backup; in case somebody's going to the hospital, you should have somebody else. Really, the optimal way and what we have right now is 12, but you can go to 20.

**Ms Carter:** Could the Ministry of Health save a lot of money by using you as a model, by getting some secrets of how you do it?

**Mr Igal Holtzer:** It's interesting you ask me this question. While we were sitting in the back, Franca and I, I told her that yesterday there was a question to Dr Toffelmire, "What percentage of patients can go on self-care?" and he said 30%. I asked Franca, "What percentage could go into our centre?" and she said 50%; Carol says 25%. Let's say we took 25%. If we go on this chart and we save \$20,000 per dialysis patient per year, take 25% of the 5,600 dialysis patients, a rough calculation, you've saved \$40 million. Not all of them will go to centres, but this is a calculation we did in the back. But you're not going to get 2,000 patients out of hospitals into those centres, because it's going to create other problems.

**Ms Carter:** But the secret is having the free-standing clinic.

**Mr Igal Holtzer:** That's our secret.

**Mrs Carol Holtzer:** A lot of it, from my perspective, from a nursing perspective, is allowing the patients the control and the freedom to be able to be in their own communities and to have nursing staff who are looking at preventive health care versus an acute care facility. The nurses and physicians at acute care facilities have to deal

with the crisis as it develops. They don't have the time. It's not that they don't want to; they would desperately love to be able to teach the people about how to keep out of the hospital. They can't; they don't have the time.

In this kind of facility, because you're not dealing with crisis intervention—and that's what the hospitals deal with—you can spend more time on things that will keep them out of hospital and in better health so that, hopefully, the long-term use of the hospital will be different. But it's a very different type of nursing and you can't do that in a hospital, because I've worked in all places.

**Ms Carter:** You seem to have the ideal facility for what the particular patient requires. You're catering, you say, for about 25%?

**Mrs Carol Holtzer:** Nobody knows; we don't know. In the United States and many other countries in the world, an extremely high percentage is out of hospital. If you take a place like New Zealand, it's almost totally out of hospital. It depends on the way you look at the system and how you want the system to work.

**Ms Carter:** I have another question, and this has come up several times already. We're told that in the US, far more people per million, or whatever measurement you want to take, receive dialysis than do here. It was suggested that one reason for this is that maybe we have a higher rate of transplants here than they might do, but I feel we haven't got to the bottom of this yet. I'm just wondering what other factors there might be. Could there be conflict of interest in the States? I understand that this is the exception, that this is the one thing that gets funded publicly.

**Mr Igal Holtzer:** It's interesting. Carol and I just came back from California and we visited a number of dialysis units there. We heard a number of times through this tour that they are looking now into eliminating the idea that physicians will own dialysis units in the US. You make your own interpretation of that; I'm not going to say why. There's a big panic there in the US now about it. That's recently. Apparently, they're looking to pass legislation January 1, 1995, about it. It's what we heard; we didn't see, but somebody told us about it, on numerous occasions.

**Ms Carter:** So there could be a problem.

**Mrs Carol Holtzer:** But you also have to look at the patient population. There are very different demographics of patients in the US than there is in Canada. Certain groups of people certainly have kidney disease more so than other people do. I'm not an expert at that; you certainly have a lot more physicians here who know those things better than I do. Patients get dialysis here, but it may take them a long time and they may be pretty sick by the time they get it.

**Ms Carter:** But they could be less successful in some way in prevention, in avoiding conditions that lead to the need for dialysis.

**Mrs Carol Holtzer:** Yes, that's very possible.

**Mr Igal Holtzer:** I want to quickly point out that we visited some dialysis units in Israel. The story is the same as the US. A lot of people have dialysis much more in Canada.



**Mrs Sullivan:** I'm interested in the chart that you have included as part of your presentation with respect to the true cost of dialysis. I wonder if you could describe more fully what in fact are the comparators in the chart. You're not including many physician services, laboratory services that should be included in the hospital base costs, I assume, or even in some of the satellite centre costs. You're not including social work costs, which would be included in the hospital base.

I guess what I'm asking you for is a more complete analysis of what these cost comparators show. My own sense is that frequently the private sector can provide a cost-effective delivery of health care services within a public system, but I think it's unfair, frankly, to have a simplified chart that presents an argument that doesn't include all the necessary factors that may well be required for a certain patient population that needs hospital delivery or satellite delivery or whatever. It would be useful if we had additional data that explained particularly how these cost comparisons were arrived at, and I think that would be useful to the committee.

**Mr Igal Holtzer:** What I suggest is that when I asked a district health council, "How do you arrive at this \$50,000 or \$47,000 a year?" they could not be very specific about it. This question was going on for 12 years, how much it costs in a hospital. They never come out and say how they get to \$50,000. I can provide it, but if you want to do a fair comparison, you have to compare apples to apples.

**Mrs Sullivan:** What was your original capitalization for the opening of the centre in Markham? What were your original capital costs?

**Mr Igal Holtzer:** About half a million.

**Mrs Sullivan:** And your annual operating subsidy from the Ministry of Health now?

**Mr Igal Holtzer:** It's a private organization, so we'd rather not get into it, but we can get it to you.

**Mrs Sullivan:** But it is an independent health facility.

**Mr Igal Holtzer:** Yes.

**Mrs Sullivan:** And it is a public grant.

**Mrs Carol Holtzer:** Yes, so you can go and get the numbers.

**Mr Igal Holtzer:** You probably could get the numbers, yes.

**Mrs Sullivan:** Okay.

**Mr Jim Wilson:** It's also a contractual agreement.

**Mrs Sullivan:** I suppose then we get into the question of the involvement of the private sector and how public that financing is going to be, and I think that's an important question when we're talking about accountability for the spending of funds. I understand that as an incorporated body, probably with limited liability and those other issues, you have competitive factors that you—

**Mr Jim Wilson:** But if it wasn't a good deal, the NDP would not have signed them up, believe me.

**Mrs Sullivan:** No, but I think it's useful to have the information.

Are you a publicly traded company?

**Mr Igal Holtzer:** No, we're not traded. We're a private company, incorporated in Ontario.

**Mrs Sullivan:** Okay. Good.

**The Vice-Chair:** Thank you for your presentation. We appreciate it.

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EDWARD COLE

**The Vice-Chair:** The next presentation will be made by Dr Edward Cole of the Toronto Hospital, University of Toronto. Welcome to the committee. Please be seated and proceed with your presentation, however you wish to do it. We have your handout.

**Dr Edward Cole:** I appreciate the opportunity to talk to you. I'm a kidney transplant person. I know you're focusing on dialysis in a major way. What I hope to do is to tell you how kidney transplantation fits into the global picture, the issues of transplantation versus dialysis, to give you some ideas of the numbers and then say what I think organizations like Parliament might be able to do with respect to this.

As you know, there are two very good treatments for kidney failure. One of them's dialysis; one of them is transplantation.

What would be the benefits of transplantation as compared to dialysis? Transplantation is not a lifesaving treatment. Its difference is not in quantity of life but rather quality of life, so the benefits of transplantation relate to more independence, not having to go to the hospital or, at home, doing dialysis.

There's a substantial improvement in feelings of wellbeing, for lack of a better term, which is the thing that patients appreciate most, and documentation by a number of different groups of an improvement in the percentage of patients who return to the workforce.

Most patients on dialysis are not able to have children, be they male or female, and the likelihood of that is much higher once they've been transplanted and have good kidney function.

There's a significant cost benefit to transplantation as compared to dialysis, and my numbers are very approximate. I'm sure you've gotten much more accurate ones about dialysis, so I don't think we need to argue about it.

But if you want to say that dialysis costs \$30,000, \$40,000 or even \$50,000 per patient per year, transplantation has a substantial cost in the first year of about \$40,000, but every year thereafter the cost is, say, \$7,000 to \$10,000. So over a period of time, over a period of a number of years—the average lifespan of our kidneys is probably in the range of seven to 10—at the moment there is a substantial cost saving to the health care system.

The patients do better, they're more likely to rejoin the labour force, and the cost is substantially lower over a period of time.

Suffice it to say, and we don't need to get into this in detail, not everyone is a good candidate for a kidney transplant. People who have significant other diseases apart from their kidney failure are less likely to do well; they are more likely to run into problems. Thus we can't

transplant everyone who's on dialysis, but we could transplant a far greater number than we're currently doing.

Just to give you some idea of the numbers, these are data from 1991 and this looks at patients three months after they develop kidney failure. How are they being treated? You can see that we're looking at about 2,600 patients. Some 2,200 of them are on dialysis and about 10% of that amount—that's only three months later—are transplanted. So most patients, the vast majority, are treated with dialysis initially. That's really the way it has to be for a variety of reasons that we can talk about later if you wish.

Most of these data are from the end of 1992, and I'll point out where they're different, but they reflect all of Ontario, as did the previous data that I gave you. At the end of 1992, there were about 5,500 patients with kidney failure, about 3,000 on dialysis and about 2,500 transplants. There were 972 patients waiting for a transplant. I'm sorry, but the only data I could get on short notice was at the end of 1993, and people on this transplant waiting list are waiting an average of two years' time.

Finally, if we look at the number of transplants that are being done in the province, I've shown you the last three years, 1991, 1992 and 1993. What you can see from the bottom number is that we've essentially plateaued, although things are up or down slightly.

We do transplants in two ways. Cadaveric donors are the ones who die in a car accident or of a stroke and so forth. They become brain-dead, and if we get consent, we offer their organs. That's the way most of our patients get transplanted. But we're doing more living donor transplantation, in part because there are advantages to it in terms of results and in part because of our shortage of cadaveric donors. We have increased our living donors a substantial percentage, although the number is still small. As you can see, in 1993, of 311 transplants, 240 or so were cadaveric and 72 were living donors.

The key points are that we've got a treatment which in selected patients is better in terms of quality of life and in terms of cost benefit, but we've got restricted access to it, not in the sense of us restricting it but in the sense that more patients could be transplanted per unit time, but we aren't doing that. Our waiting list is growing, and this issue of dialysis overcrowding is exacerbated by the low transplant rate.

The point that was on my transparency at the beginning that I don't think I mentioned is that an additional advantage of renal transplantation is that it's one of the ways in which we get people out of the dialysis unit and create new dialysis spots dealing with the same number. There are basically only two ways for the most part: Either the patient dies or the patient gets a transplant.

Our major problem in terms of transplanting patients is really the supply of cadaveric kidney donors. We looked at this some years ago. The reasons we don't have enough donors are multifactorial. It's clear that the medical team is not doing its best in terms of looking at every patient who dies as a possible organ donor. They aren't doing their best in terms of approaching families.

We probably all don't have the ideal technique in terms of dealing with families in what is obviously a very traumatic situation, because by definition we're dealing with the families of patients who were quite well. They were living, for the most part, pretty normal lives and then, suddenly, they have a catastrophe. The emotional trauma is quite difficult and a physician or surgeon is going from trying to save a life and doing everything he or she can to then asking for an organ. I'm not saying we shouldn't be doing better—we absolutely should—I'm simply pointing out the difficulties.

There are still a number of patient families that, for a variety of reasons, refuse to give consent. Perhaps I should leave some of the reasons for the question period, if any of you are interested, but we can get into that.

The final issue is that in order for somebody to become a donor—let me take a step back. Suppose somebody has a massive bleed into their head and dies. If they die, if they basically lose function and the doctors decide there's nothing they can do, what they'll generally do is they'll often turn off the machinery and then the patient dies, is pronounced dead etc.

What happens with organ donation is that, first of all, they have to keep them on the breathing machine until they can prove that they're brain-dead. They have to go through extensive testing, certification by two physicians. They then have to stay in that intensive care unit, because all of these patients are in that, while they are assessed as donors, because we can't really assess them very well until we have consent. They need to stay for a number of hours. They have to be maintained. They still need the same acute nursing and medical care.

You all realize, I'm sure, that as well as a shortage of regular hospital beds, critical care beds are short. The number of them in this city has been reduced substantially from what they were some years ago. We're asking hospitals and doctors to keep these patients, for whom they do nothing, in critical care beds longer.

Number two, there is a cost involved in keeping them in beds longer and in the surgical procedures in terms of nursing etc involved in harvesting the organs. Up until the present time, there's no mechanism for reimbursing hospitals for the donors they contribute. In essence, there's a net negative cost to a hospital in terms of the donation per se. If you're a neurosurgeon who has got a call from Joe Blow, God knows where, who wants to get a patient in who hasn't even been investigated, so you don't know if you can save him, and you've got somebody you are waiting to certify as an organ donor whom you've already decided there's nothing you can do for, it creates a very difficult decision for that particular individual. So there are a variety of issues there that can be addressed.

What can the government do? One of the issues, and I'm sure this has come up in terms of dialysis, is that the life support funding mechanism was a mechanism to allow us to fund as many of these cases as we can do. Our transplant rate is plateauing, but I think it's important conceptually that if we could double our transplant rate, it would be critical for our hospitals to know that they would be able to get the costs covered for that. I think



it's as important in its own way in this as it is in dialysis.

Number two, I think we need to continue to foster public education. Many people still don't believe that if their family member is an organ donor, that will not impede their medical care one iota. That's a critical issue as well as the fact that transplantation is not an experiment, and all of the various successes.

I think that the issue of legislation relating to consent in organ donation is one that we could perhaps discuss further, depending on what your interests are, but it's clearly an area where government can play a role.

The issue of funding hospitals for organ donors I think is an important role.

1750

Finally, you may have heard from some of my colleagues earlier about the drugs that are currently funded by the government. One of these is cyclosporine, which has improved our transplant survival rate by 20%. It's made a huge difference. Without this drug, which costs about \$5,000 or so a year, the success of our transplants would be far less and the costs and the overcrowding of the dialysis unit would be far more. So it makes sense in purely fiscal terms to continue the funding of this drug.

The threat that was raised a number of months ago, which I hope we've put to rest but I don't know, is really a very critical issue. It makes no sense in any kind of terms to continue.

**The Vice-Chair:** Ready for some questions?

**Mrs Sullivan:** Just to start, we have asked for a confirmation from government that the life support funding formula is going to continue, and we hope we get an answer. Maybe tomorrow would be good, but I won't guarantee that will happen. Certainly it's a matter that we feel quite strongly about and I know it's a matter of enormous importance to hospitals that are doing this work.

You talked about several areas of consent that I'm interested in following. With the new consent legislation that is now waiting to be proclaimed, I'm thinking of two aspects of that. One is Bill 208, the living will piece of legislation, and the other piece of legislation is Bill 109, which is the Consent to Treatment Act.

If you have a patient who is in the position of having signed a donor card, and then you have a patient who is technically mentally dead or technically dead I guess but not really dead because he's still hooked up, only for mechanical reasons or only for medical reasons, for the transfer, where does the consent come from?

**Dr Cole:** Consent comes from the next of kin. It's a good point. What we would use the donor card for is that sometimes the next of kin don't know what the individual would have wanted and they're placed in a very difficult position. If we can show them that the unfortunate individual who's died has indicated previously that he wanted to be an organ donor, then that often influences them in a positive way to agree on his behalf, but basically we do not use the driver's licence as enough of an indication for us to go ahead.

**Mrs Sullivan:** Presumably, until we had some kind of legal remedy such as a presumption of consent, the power of attorney for personal care, ie the living will, the power

of attorney that specifically directs the substitute in a certain way, would be the most positive interim mechanism for you.

**Dr Cole:** Yes. I must confess that you're probably a lot more knowledgeable about living wills than I am, but I wasn't aware that would impact on organ donation in a major way. I thought it was more related to how far one would go in resuscitating people etc.

**Mrs Sullivan:** I'm not sure. I guess that's why I'm asking the question. I'm wondering if it would be a tool.

**Dr Cole:** I must confess that I don't know enough about the living will legislation to know what issues it covers, but neither I nor my colleagues who are also involved in the organ donation issue have ever suggested that would resolve it.

The presumed consent issue: I don't know if you want to discuss it or not, but it's a more complicated issue. I guess what we're moving towards in Ontario is something that says that we'd like to have some evidence that when a patient died, he had the opportunity or his family did for him to be an organ donor. That's really a fairly loose thing, and to the best of my knowledge there isn't any audit that's going to be in place absolutely that is really going to push people into doing this, and it's not all that strong. This leaves it up to the next of kin really.

Presumed consent says that you are presumed to be willing to donate your organs unless you or your next of kin state otherwise. There are several potential problems. There are pluses and minuses. In Austria and in Belgium, it's improved their donor rate extraordinarily. In France, it hasn't worked at all. There are a couple of potential problems with it.

One is that it's been suggested that different societies react differently to the, if you will, loss of individual right to make these decisions and that some feel many people will become more alienated from the system with this. Number two, in France, there was a legal challenge to this which got a lot of play in the press. It's never been ironed out and it hasn't improved their organ donor rate.

The organ donation organization in Ontario, with is called MORE—multiple organ retrieval and exchange—has recently commissioned a study looking at how appropriate it would be to draft presumed consent legislation in Ontario. It's not in its final format. It's only in an interim one. Thus far, they are not convinced that it would be beneficial, but a lot of the arguments against it are philosophical; the ones in favour of it are pragmatic. I think it's a matter of opinion. Many of us are more pragmatic. But that's where it stands.

I don't think the transplant community yet knows what it wants, but hopefully it will soon and you might consider getting a copy of this final position paper from MORE. I could certainly direct you to the right place if you're interested in hearing about it further.

**Mrs Sullivan:** I think they're going to be witnesses and may discuss this issue.

**Mr Jim Wilson:** Thank you, Dr Cole, very much for your presentation. You were succinct and to the point and did a very good job because, I guess it was a couple of

years ago, I thought we saw some light at the end of the tunnel with respect to organ transplants. Frances Linkin, when she was minister, I think had a very sincere interest in the matter. I remember going to many, many meetings around her board table with MORE and I thought, I had the sense, as critic, that the government was really moving on the issue. Let's be fair to the government because it's its turn to ask questions next. Have they moved, have they tried, or are they bogged down for lack of funding, or what's the problem?

**Dr Cole:** I don't think this government has done a bad job. I didn't know who was on what side, I must say, but I don't think this government has done a bad job with respect to transplantation particularly at all. They certainly haven't done a worse job than the people before them and, for the record, Mr Rae has been very committed to transplantation per se, as well as the party. That isn't what this is about.

**Mr Jim Wilson:** Okay, but I've been to a lot of meetings where I've heard that and yet as critic I keep getting letters, people saying nothing's improving.

**Dr Cole:** Well, yes. I think there are two issues: one is whether something's improving or not and two is, can you assign the blame to the government for nothing improving? I think I've raised a number of issues where I feel the government can play a role. I think that if the government threatens life support funding, that's going to be a problem. That has not impacted up until now on kidney transplantation. I think they have fostered public education. I wasn't being critical of them in that role.

Neither I nor my colleagues have perceived government as a barrier. In terms of legislation, as I indicated before, there are a number of different points of view about what legislation would be the best from our perspective and I think we have to wait for that final opinion so they can take some of our direction. I don't think they've been a barrier.

I think the donor funding issue is an important issue and this government hasn't done any more or less than the one before that and the one before that. One of the previous governments, and I can't remember, I'm afraid, which, did ask for our donor costs hospital by hospital, but as far as I'm aware I don't think it did anything with the information. We haven't been asked about that recently, but I think donor funding is an issue. The government of Quebec has recently stipulated separate donor funding, and according to what they say in Quebec, that has made a difference. I think that is an issue government can take up.

I think the threatening to cut off the funding for cyclosporine, in my view, was a potential major blunder, but I must say that when we brought the documented information of its benefit, at least at that point we got the impression that they were backing off fairly quickly.

1800

**Mr Martin:** I've only had one personal experience of the whole donor process and it was quite a learning experience for me and quite a moving experience to watch the decision being made to donate the organ and then the sensitivity of the doctor involved and all of that.

I wasn't able to ask any questions about a couple of things at that time, which, though, did raise some question in my mind. The word went out that there were some organs available and then we had to wait quite a period of time until we got a response to whether there were potential recipients out there. How much of a problem is that and why is that a problem?

**Dr Cole:** Understanding that it's difficult to comment on a particular case without knowing all the details, in general, let me say that there are some patients, for example, an unfortunate 19-year-old who's absolutely healthy who dies in a car accident, who has been stable, as it were, even though his or her brain is no longer functioning, has been quite stable, hasn't needed a lot of extra drugs, where one could be reasonably confident that we'd want to use heart, lungs, liver, kidneys, bone. Okay? There are other situations where people have been more unstable, where, let's say, they're 65 or some such thing, and they may have had high blood pressure in the past etc and one needs to take some time to try and understand the details of the case more and offer the different programs these organs.

The timing is such that in terms of things like heart and liver, you have to really be ready to do the transplant when you take the heart out sort of thing, and you don't want to do all of that before. So most of the time, if there's a donor who doesn't have any of these problems, we can decide quite fast that at least we want some of the organs and we work through it. Sometimes the donor's been exposed to a virus, hepatitis virus or something, and it becomes a bit more complicated. Most of the time it's not complicated to decide that we want to use a donor.

There are viral tests that we do on the blood for various kinds of hepatitis, for the AIDS virus, that we have to know the answer to before we can transplant because otherwise we would be passing on a virus which would be creating a disastrous problem, and those can take several hours. When those start may be a bit variable, so that would be another potential delay.

**Mr Martin:** You talked about the need to do public education around this and certainly funding is always a big issue as well. One of the things that happened, again, in this instance was that your organization, MORE, was recognized as a place a person could make a donation in terms of the funeral. How much money actually comes in through that avenue and is it significant to your work?

**Dr Cole:** I'm afraid I just don't know the answer to that. I'm involved more by virtue of my involvement in transplantation; I'm not a member of the board nor involved in them that intimately, so I just don't know the answer.

**Mr Martin:** One other question, then: There was some reference yesterday to some experimentation being done in the area of mechanical organs being available and also there was a mention of kidneys from pigs. Where are we at with that?

**Dr Cole:** I think where we're at is that aside from whatever one thinks of the ethics, which I don't think this is the time or place to get into, there is ongoing research in this area of organs from animals. We're a long way away from being able to successfully do those. It's



definitely possible in the future, but it's not going to happen next year or two years from now or whatever.

**The Vice-Chair:** Thank you. Ms Sullivan, did you have a—

**Mrs Sullivan:** Yes, I had a supplementary; I told the Chairman it was a supplementary but it's on a totally different subject.

The human resources planning in all areas of health care is fraught with difficulties and usually, when we find that there are problems in adequate resources, we find that human resources aren't very far behind. If there were an incremental number of transplants, would we have the adequate human resources in place to ensure that needs were met, and with the new planning or with the new directives that are being put into place with respect to medical training, are we ensuring that we are in fact training the specialists required for transplants?

**Dr Cole:** I guess it would depend on how big an increment. If I told you that we could double our transplant rate and have enough human resources, I'm sure what you would say is, "Then you're wasting a lot of our money by having far more people than you currently need."

If we increased our transplant rate by 5%, yes, we'd have the human resources to cover it, if you mean doctors and nurses and the ancillary people. But if we increased our transplant rate by 30% or 40% or 50% or more, we absolutely wouldn't because even our nurses, who are supposedly on an 8-to-4 or whatever you want to call it schedule, are working a lot longer than that every day. So no, there would definitely have to be an increment in the funding for human resources because in this, maybe more than many other areas of medicine, the doctor is only one of the very large numbers of individuals who are critical to the success of these programs. So no question about that.

The second thing is that you need to spell out for me

what you mean by "new directives" in medical education. If you're talking about licensing requirements, I don't—

**Mrs Sullivan:** No, I'm talking about admissions to medical schools.

**Dr Cole:** I don't think that the primary purpose of most medical schools is to train people to do tertiary or quaternary care medicine, which is what transplantation is all about. We have tried to modify our curriculum, an area that I've been involved with, so that we include transplant-related issues, donor-related issues and the importance of those things so that people will be aware of it. But I think that if the government continues to cut the number of specialty or subspecialty residency positions that are available, then you're absolutely right that we won't.

I don't think in terms of medical school issues that I could necessarily say there'd be a problem, but I think there's always going to be a requirement for a variety of individuals in this province and country, and not all the programs are fully staffed around the province. I think if one continues to cut the funding to these positions, then there will be a problem, not only with transplantation but with all areas of kidney disease, absolutely.

**Mrs Sullivan:** Thank you. I very much wanted to get that on the table.

**The Vice-Chair:** Anyone else?

**Mrs Yvonne O'Neill (Ottawa-Rideau):** Mr Chairman, I just wondered how many hours we have used to this point.

**The Vice-Chair:** We'll advise you shortly. Anything else? If not, thank you very much for your presentation.

**Dr Cole:** You're welcome. Thank you.

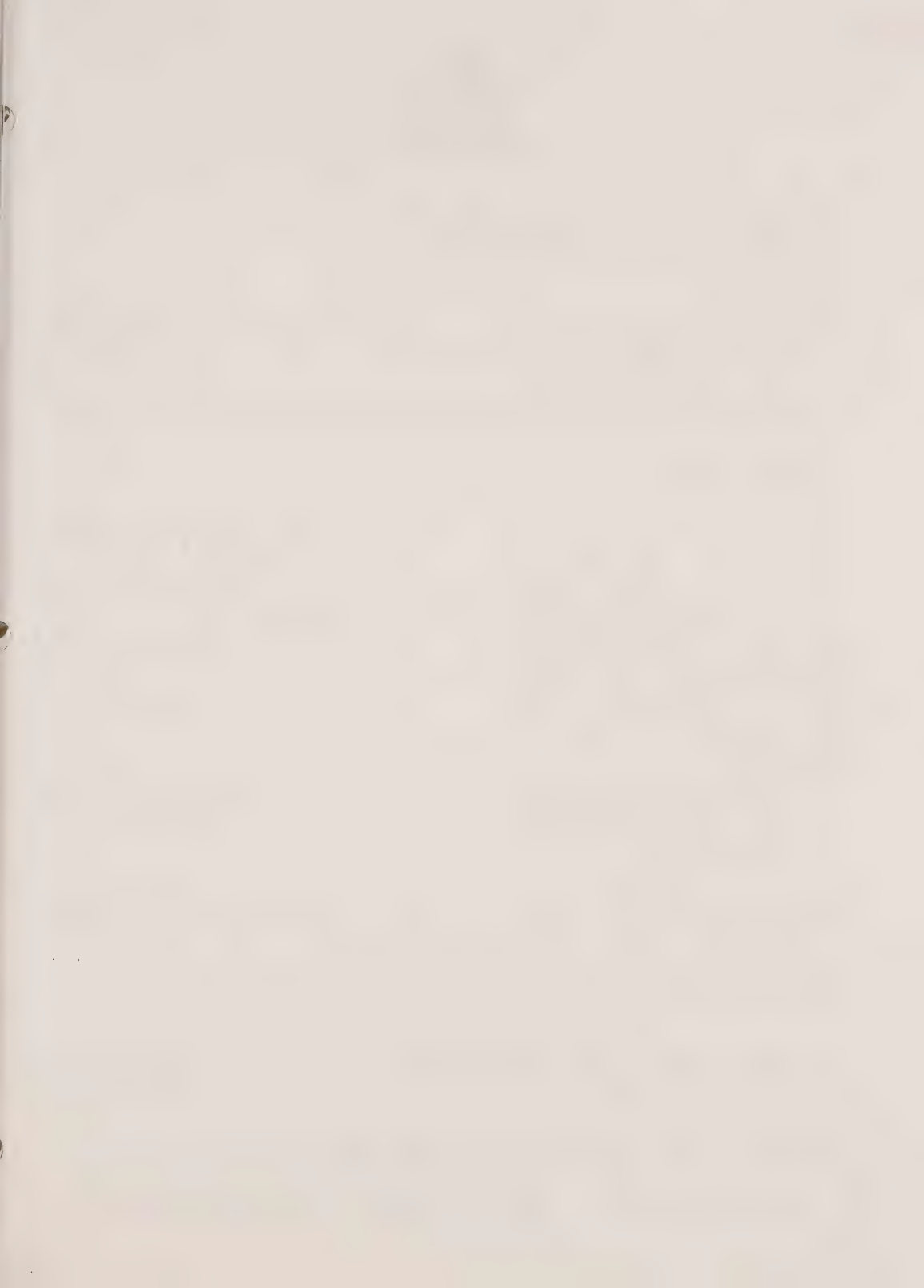
**The Vice-Chair:** The standing committee on social development stands adjourned until April 18 at 3:30 pm.

The committee adjourned at 1807.









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### **Substitutions present / Membres remplaçants présents:**

Haslam, Karen (Perth ND) for Mr Hope

Sullivan, Barbara (Halton Centre L) for Mr McGuinty

Wessenger, Paul (Simcoe Centre ND) for Mr Owens

### **Also taking part / Autres participants et participantes:**

Wessenger, Paul, parliamentary assistant to Minister of Health

**Clerk / Greffier:** Arnott, Doug

**Staff / Personnel:** Gardner, Dr Bob, assistant director, Legislative Research Service



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of Ontario**

Third Session, 35th Parliament

**Assemblée législative  
de l'Ontario**

Troisième session, 35<sup>e</sup> législature

**Official Report  
of Debates  
(Hansard)**

**Monday 18 April 1994**

**Journal  
des débats  
(Hansard)**

**Lundi 18 avril 1994**



**Standing committee on  
social development**

**Comité permanent des  
affaires sociales**

**Dialysis treatment services**

**Services de traitement par dialyse**

Chair: Charles Beer  
Clerk: Doug Arnott

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## LEGISLATIVE ASSEMBLY OF ONTARIO

## ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON  
SOCIAL DEVELOPMENTCOMITÉ PERMANENT DES  
AFFAIRES SOCIALES

Monday 18 April 1994

Lundi 18 avril 1994

The committee met at 1531 in committee room 1.  
DIALYSIS TREATMENT SERVICES

Consideration of a matter designated pursuant to standing order 125 relating to dialysis treatment services.

**The Chair (Mr Charles Beer):** Good afternoon, ladies and gentlemen. We are continuing our review of dialysis treatment services in the province. We have a full agenda today. Bob Gardner will draw attention to two documents which are in front of committee members.

**Dr Bob Gardner:** One is a summary of the first two days of hearings from last week. Members will note that summary is in a slightly different style than the summaries we do for bills. There are some prose-linking passages and summary passages that pull together the various bullet points, specific points from the various witnesses.

The reason for that is both analytical, in the sense that it makes more sense of a complex issue, but also that we do that with the anticipation that members may want to put that summary in their actual report, in terms of what the committee heard. As you look at it, you may give some thought to that in terms of how you would see adapting it for the report.

You may also want to look at the sections and the issues that were brought up in the summary in terms of thinking on instructions for us for the report, those instructions which you can give tomorrow.

Finally, there is a draft report, anticipating your instructions, and this is technical material from the ministry, a summary of the minister's statement and the various definitions and descriptions that I put together some time ago for you. Likely that would go in the front of the report, then the summary and then your conclusions and recommendations and so on at the end.

**The Chair:** Fine. If there are any questions on that, speak to Bob later this afternoon or tomorrow. We will move to our first presenters.

## CENTRAL EAST REGIONAL DIALYSIS COMMITTEE

**The Chair:** Welcome, Lyn Linton, chair of the steering committee, central east region review on dialysis services, and Graham Constantine, executive director, I hasten to add, not of the York region health unit but of the York Region District Health Council. I knew if I didn't say that, Mr O'Connor was going to say it.

**Mr Larry O'Connor (Durham-York):** That's right.

**The Chair:** I thought I should jump in. Please go ahead with your presentation.

**Ms Lyn Linton:** Thank you for having me here

today. I am going to have Graham read my speech.

**The Chair:** Is there a doctor in the house?

**Ms Linton:** I feel very fine; it's just my voice. I sound like a cellular telephone—in and out. I'll save my voice for the questions, which I'll answer at the end of it.

**Mr Graham Constantine:** I think the committee did receive copies of the notes.

"Good afternoon. I'm Lyn Linton, a volunteer with the district health council and chair of the Central East Regional Dialysis Committee. I am pleased to participate in these hearing sessions and I'm happy to have the opportunity to speak on behalf of the Central East Regional Dialysis Committee. My report to the committee focuses on the role of the district health councils, the impact of regional planning and, within this context, the goals of the dialysis committee. Before I begin, I would like to address one of the motivational factors which draws me here today.

"A few weeks ago, on a Sunday, I was watching on television the parliamentary proceedings for that week. With interest, I was listening to a member of Parliament speak to the House on his concern for dialysis services in the province. As part of his speech, the member stated his 'lack of confidence' in the dialysis committee.

"Thousands of volunteers on behalf of the district health councils across this province are committing their personal time and collective experiences by willingly taking up the challenge to improve upon the delivery of health services. We have been doing so for some 20 years, since the inception of the district health councils. During this time we have developed skills which successfully allow us to manage the change process.

"We are individuals who are not only prepared to give of our time but of ourselves, setting aside our partisan politics and our personal feelings in order to listen, and then to listen again. We facilitate, mediate and move communities from current realities to preferred futures. In return, we ask for trust in our abilities and the confidence that, if given the opportunity, district health councils and their volunteers can and will make a difference.

"In order to meet expectations of our communities, it is important that our role be understood. Originally district health councils were given four main tasks: to identify health care needs in communities and recommend ways of meeting them; to establish short-term and long-term health care priorities; to coordinate health planning activities within their communities into an effective and efficient system; to work towards cooperation in the social development activities of their communities.



"In 1989, the role of the district health councils was strengthened and enhanced to include providing advice to the Minister of Health on changes in health spending; requirements for human resources in health care; strengthening area-wide planning, which is regional planning with other district health councils; and integrating health and social services planning.

"To achieve this mandate we must put into proper context that district health councils do not govern, manage, operate or fund any health services. Rather our role focuses on providing a process which enables local communities to recommend local solutions to issues impacting on health services and delivery. Decentralization of the planning process promotes a broader understanding of factors affecting health services and allows for accountability and ownership in developing resolutions. To accomplish these outcomes, DHCs work hard at maintaining the integrity of the process and its added value to participants.

"Building on that strength, district health councils and the Ministry of Health are now focusing on a regional approach to planning for those services which identifies an arbitrary pattern of health service utilization, that is, individuals or communities which cross borders for services; requires access to tertiary services; promotes a critical mass approach for better outcomes; seeks economies of scale which could be achieved through shared planning.

"A regional planning approach also promotes and facilitates an improved communications network and ultimately a stronger political voice. For regional planning to be successful, basic principles which guide the process are crucial, not only for DHCs within a region but for local communities participating.

"Such principles would include merging of partnerships between stakeholders, which is built on trust and equity; ensuring that local citizens are involved in the decision-making and planning processes; local issues and concerns being given due consideration and influence in any broader planning initiatives, with all of their stakeholders having a thorough understanding of their involvement; effective and efficient communication linkages, both laterally and vertically, between all stakeholders; undertaking issue- or program-specific services which would transcend existing district boundaries, involving all DHCs within that region; ensuring that the process was enabling and not encumbering; finding a process which would build on the collaborative and collegial attributes at the district level; and where due consideration must be given to planning, implementation, monitoring and evaluation phases during the process of planning.

"This leads me to speak specifically about dialysis and why a regional planning approach is being taken. Not only does dialysis fit the criteria, that is, it transcends cross-borders, requires access to tertiary services, and possible economies of scale could be achieved through shared planning—but it also has identified itself as an issue within the six DHCs' regions.

1540

"Central East is comprised of six district health councils: Durham, Haliburton Kawartha and Pine Ridge,

Metropolitan Toronto, Peel, Simcoe and York. Its population represents 44.4% of the provincial total and contains some of Canada's fastest-growing areas. In 1990-91, 44.7% of the total provincial expenditures were allocated to this region. Additionally, it has the largest multicultural population and is challenged by meeting the needs of a large urban population as well as sparsely populated rural areas within our region.

"The planning design for the central east regional study on dialysis provides for a balance between the needs-based planning approach and a consultative methodology involving significant dialogue with the community of consumers and their care givers. Included in the design is the need for a communications strategy which will both elicit ideas and opinions about system change and inform stakeholders of current economic and fiscal realities of health care.

"Composition of the steering committee consists of consumers of dialysis services and care givers, DHC representatives as well as institutional and community-based providers. A technical advisory subcommittee has been instituted to provide the steering committee with expert opinions and is made up of providers of dialysis services. The composition of the steering committee is designed expressly to maximize the community-based character of the planning process.

"The steering committee will be the structure through which the study will be conducted and the regional plan developed. The function of the steering committee is to lend a strategic focus to the development of the regional plan. Consultants will be retained to work directly with the steering committee in the development of the strategic directions, alternative strategies for the alignment of services based on the identified needs of the population, the availability of human resources and the development of an implementation plan.

"We view the critical elements of the study to be inclusive of extensive consultation with stakeholders, including hospital boards and management, health care professionals, hospital staff, community health and social service agencies, existing health care-related committees, physicians and consumers. The support and 'buy in' of the stakeholders is critical to the success of this project. The expected outcomes for the final report will include the following:

"—An analysis of the population requiring dialysis services in central east.

"—A determination of the resources required to meet the needs of the population now and in the future.

"—An analysis of services in place, their location, capacity, utilization, relationship to the sources of need and their current success in meeting the needs.

"—Development of alternative courses of action to better meet the needs, within available resources.

"—Recommendation of a preferred option for the immediate and long-term needs.

"—Recommendations for service linkages, integration, rationalization and the reallocation of resources between organizations and between the institutional and non-institutional sector in order to ensure that the service

system is responsive to identified needs.

"—Recommendations as to how the preferred option should be implemented and who has the responsibility and authority to monitor its progress.

"—Recommendations as to how the population's need for the dialysis services is to be updated and monitored.

"The final report will be submitted to the central east district health councils for approval.

"Taking on a project of this magnitude is no small feat, and in order to maximize the chances of success, the 'planning to plan' or preparation cycle has required a great deal of time for various reasons:

"—We are creating a new model for regional planning. There have been no previous studies of this scale using the new DHC approach.

"—Mobilization of communities and organizations to appoint members to the committee"—and we note that all the appointments are incomplete at this time.

"—Consideration of the number and mix of stakeholders in a population of 4.4 million.

"—Until funding was received, the project was entirely supported by the CEOs of the Peel and York DHCs.

"We believe that every effort has been made to ensure that the final outcome of this study will be of value not only to the funders and providers but, more importantly, to those who require the services.

"Thank you."

**Mrs Barbara Sullivan (Halton Centre):** I'm interested in the way you have approached your presentation to the committee, first of all, with a discussion of the role of the district health council and then moving into the specific work of the steering committee.

The first question I have is with respect to the role of the district health council. We have seen over a period of time increasing responsibilities being asked of district health councils and some deep and abiding concerns that the resources, both human and financial, are not available to the DHCs so that they can carry out their mandates.

Furthermore, there is concern that frequently there's an overlap with a role, by example, of the academic science centres in terms of strategic analysis. I just wondered if you would comment on that and if you have recommendations with respect, by example, to a district health council act or other mechanisms.

I know, Mr Chair, that this question could in fact create a three-hour response—

**The Chair:** No, it won't.

**Mrs Sullivan:** It won't. The Chair is very good.

Then if I could just tell you that my concerns with respect to the steering committee on dialysis are that we have had discussion through Dr Janet Roscoe that indicates direct correspondence of the Toronto Dialysis Committee—and David Mendelssohn, who is vice-chairperson of the Toronto Dialysis Committee—with respect to recommendations from that committee, which certainly has credibility with respect to the professional judgements that are being put forward; with respect to very specific initiatives that should be put into place to

ensure that there is an adequate level of dialysis services available in the area served by the Toronto committee.

There is also a second letter from Dr Roscoe which indicates that the committee, which presumably is the DHC steering committee, as of March 29 had met on only one occasion. We understand the subsequent meeting was cancelled and there was no nephrology representation on the committee. Could you respond to that?

**Mr Constantine:** We actually met twice. The technical advisory committee and the steering committee met on April 15. On March 24 there was a meeting of just the DHC members on the committee and the ex officio members. There were no other representatives. We were trying to do some orientation for the DHC members, both in the process of regional dialysis and the process of regional planning.

I'm just going back to the second-last question, the comments made with regard to the immediate problems in accessing dialysis. I understand, and it has been recorded here in the standing committee, that the ministry has taken some initiative to resolve some problems on a one-time basis for this fiscal year. I'm not sure whether you've had that brought to you or not yet.

**Mrs Sullivan:** We have had information with respect to action that was taken by the ministry in November. However, that action was really to move funding that should have been spent on the Sussex Centre, because the Sussex Centre hadn't opened. That funding has not continued and in fact may not have been spent.

**Mr Constantine:** But there is another initiative and there were two meetings called of the CEOs and the chiefs of nephrology, of the providers of dialysis, on March 18 and on April 7, where they were advised that we were one-time funding for this next fiscal year to solve some of the immediate problems.

**1550**

Going back to your first group of questions, in my opinion the funding for the dialysis study is adequate. I think there are some ongoing funding problems with the district health councils, which I think the ministry is trying to resolve at this time. As new initiatives are coming out—long-term care, mental health reform, and possibly cancer—they are attempting to augment the existing resources of DHCs.

**Mr Jim Wilson (Simcoe West):** I want to make clear that really the frustration that's experienced by patients essentially has been directed at us as politicians, and I guess from time to time we've directed it elsewhere. I certainly make any apology if it offended the DHCs, but the frustration really is directed at the Ministry of Health.

This is not a new issue. I've only been Health critic for three years and dealing with it for three years. We've had attempts at these studies before. They've not been, for many, many reasons—and we've had witnesses appear before the committee explaining why these studies haven't seemed to have gotten off the ground. I guess there is frustration and a real impatience out there and I'm sure you sense it too, particularly as volunteers.

Given that, I'll just ask you a very direct question: Given all of the concerns and problems you've outlined



for us in your presentation today, when can you get the final study done? As you know, the ministry will not move to even short-term solutions without that study.

**Ms Linton:** Our first meeting of the technical advisory committee was April 15, on Friday, and then we had the chair and the vice-chair of that committee come on to the steering committee on Friday afternoon. The next meeting will be on April 20, this week. The clock started ticking, in our books, on April 15 for a six-month study.

As you know, now there is still some process that has to be followed. One is the selection and agreement to the consultants who will do the study, and that will happen over the next three to four weeks, at the maximum, hopefully, five. Once the consultants come on board, my experience in other studies is that it starts to move very quickly.

Once again, our focus is trying to do a very good study, one which is of value. I recognize the frustration on the part of many people, but if you rush this and it's not a study that can be implementable, then I don't think we've done our job and I think then we may have wasted the money that could have been spent.

I want to proceed. I think the foundation is there, I think we've selected excellent members. Janet Roscoe, by the way, is on the steering committee. We could not make that selection on behalf of this technical advisory committee. They were asked to vote their own chair and vice-chair, and Janet Roscoe is on the steering committee.

**Mr Jim Wilson:** I appreciate that response. Can we help you in the appointment of members to the committee? There are still some vacancies, I understand. One of the reasons we're having these hearings is to try to speed up this whole process, really, from the government's side of things. Are you missing key people that we could probably find in our communities for you?

**Ms Linton:** It is frustrating on our part as well, because we have sent letters out and we have waited, and sometimes we've had to send second letters out to get membership on to the committee. That delays the process.

We can't move forward until all of the members are there, although we have held the first meetings on April 15. We are missing, I believe—the College of Family Physicians has not forwarded a name to us, and that's the one that will sit on the steering committee. We have the two technical members on the committee now.

We were pleased with the representation on the committee from consumers that were present. We have a member from the kidney foundation, a volunteer on their board. So it's a well-rounded committee and will represent very nicely the views of all of the citizens.

The other thing we have to remember is that we have geographical territories that need to be represented. Jenny Carter is here today. She knows that there are many needs of members for dialysis in our region. Their needs need to be heard, and we need to put a balance in our region of the urban needs versus the rural needs, and we have representation from across the counties as well.

**Mr O'Connor:** Thank you for making your presentation today. I hope we don't strain your voice too much.

The planning process I think is important, because as

we move forward in taking a look at exactly what services are needed, we need to take a look at exactly what's available.

I noticed with some interest an article in a newspaper down in eastern Ontario about, "Legion Branch Donates \$150,000 for a Dialysis Unit." The Legions throughout Ontario, and a number of service clubs, are always terrific at coming through in a pinch and helping out in that way.

My concern is, is there a way that those people could be pulled into the process so that they can be talked to in part of this planning, because they may represent part of a community as well. They don't mind donating the money, because they do have some fund-raising elements that they do, but it's got to be targeted. The planning has got to take place, and they may want to be involved in some of that process as well.

**Ms Linton:** As I stated in my speech, we're looking for a very extensive consultation throughout the entire region, so that includes the east part of the Haliburton-Kawartha area up to Metro Toronto around. And you're right: I think service clubs have a lot they may be able to contribute and have been contributing over the years, and they too will have a say.

**The Chair:** Thank you both very much for your written submission and also for answering our questions. Good luck with the committee, and we hope, Ms Linton, that you're feeling much better soon.

**Ms Linton:** Yes. I hope so too.

**The Chair:** If I could then call on our next presenter, Dr George deVeber, consultant on medical affairs with the Baxter Corp.

**Mrs Sullivan:** One point, Mr Chairman, while Dr deVeber is coming forward: I wonder if we could have clarification from the Ministry of Health as to whether there in fact has been new one-time funding on an interim basis with respect to dialysis in the central east region. When the minister was here on April 11, she made no reference to any new funding other than the \$100,000 for the study itself, and I really would appreciate some clarification.

**The Chair:** We'll get the answer to that. Thank you.  
GEORGE deVEBER

**The Chair:** Dr deVeber, welcome to the committee. Please go ahead with your presentation.

**Dr George deVeber:** Thank you. I have a bit of laryngitis, but I don't think I caught it from Ms Linton.

**The Chair:** It's important that you don't sit in the same chair.

**Dr deVeber:** It must be a bad room for that.

I'd like to thank the committee for inviting me to appear. As I understand it, I was invited by the ministry to give you some information about a newer form of dialysis using cyclers for peritoneal dialysis, which we believe will certainly fill a niche and help some patients and maybe help take some of the pressure off.

But before that, I should mention I'm really here wearing three hats. I'm one of the more elderly nephrologists in Ontario. I see a couple of older ones, like Dr



Rabin over there. But I had the privilege of—

*Interjection.*

**Mr O'Connor:** He's saying, who's older than who?

**Dr deVeber:** Well, we'll see if we'll get into that eventually.

**The Chair:** I should note that the committee is very respectful of age.

**Dr deVeber:** I wouldn't want to comment on that. But I had the privilege, I guess, of being around in the mid-1960s and was involved in starting up one of the first dialysis and transplantation programs, at the Toronto Western Hospital. Of course, prior to that no therapy was available at all.

When we started up, of course, access was restricted and we had very severe rationing, because we could only take one or two people at a time, and we indeed had a selection committee, where we sat around and decided if somebody had a PhD and two children and was married, they would be more superior than some poor other person. It wasn't very pleasant, and I'll get back to that in a minute.

Dialysis then developed, and in the 1960s the only chronic form available was haemodialysis. There was sufficient funding, because the health care program and the provincial plan had come in and there was pretty well unlimited expansion, as most of you know. By the mid-1970s, we were getting full and having some problems with access. Then at that time the technique of CAPD was introduced, actually at the Western Hospital, by Dr Oreopoulos, who was the first one to really utilize it.

That took a while to get going and it wasn't really till the early 1980s that peritoneal dialysis was being accepted as an equal therapy to haemodialysis. A lot of the nephrologists were inherently resistant, as we all are, to change. It took quite a while, but eventually it became evident through several studies that both forms of therapy are completely equivalent in terms of survival and complications and so on. We have a problem with peritoneal dialysis, which I'll talk about later, in that a significant number of patients end up as technique failures and have to go to haemodialysis.

1600

We solved the funding problem by expanding a modality. Then, in the late 1980s, with transfer payment freezes and so on, it's just been getting worse and worse year by year. I was at the hearings last Tuesday and I've read the other reports. I'd really like to just emphasize what everybody else has said: We're getting into a progressively worse crisis. We have an increase in numbers of patients every year. We have flat funding or virtually very little increase in funding. It really has to be dealt with.

The other hat I wear is that I was involved in the Kidney Foundation of Canada from the very beginning and I'm still involved with its government relations committee, which was responsible for this working group on renal services. I would like to urge this committee and the ministry and the district health council to pay close attention to what their findings are and what their recommendations are, because I don't think we should have

duplication. In terms of planning, I wanted to mention that perhaps we should have in Ontario something like they have in BC, where one agency, a government agency, actually runs all of the home dialysis programs, does all the budgeting and funding and so on. In Nova Scotia they have a government agency which actually deals with centre and home dialysis. It's almost like having an outside agency which really deals with it all the time.

I'll go on to what I was originally asked to do here and tell you about cyclical dialysis, but I just wanted to mention that Baxter Corp was the first company to make a commercially available haemodialysis machine and it was also instrumental in developing the technique of CAPD along with Dr Oreopoulos.

Since that time, we've been very active in education and training and looking at demographics and quality assurance in peritoneal dialysis. We have a program called the BDP, or the best demonstrator practice program, which really looks at all aspects of how to do peritoneal dialysis better and how to keep people on peritoneal dialysis so we can take some of the strain away from haemodialysis and provide adequate care.

I'm just going to start showing some slides here. If you look at the choice that patients have when they come to dialysis, there are a small number who will definitely do better on peritoneal dialysis for medical reasons and a small number who will definitely do better on haemodialysis for medical reasons. It's probably about 15% to 20%. But the vast majority of patients can do equally well on either.

I mentioned before this best demonstrator practice program we have. What this pie chart represents is a look at 2,000 patients who were on peritoneal dialysis for a period of about three years. If you go up at 12 o'clock, in the red, you can see that 40% were still on CAPD—

**The Chair:** For those of us laypeople, CAPD is?

**Dr deVeber:** Continuous ambulatory peritoneal dialysis. Sorry. It has been talked about in the committee quite often, so I assumed everybody knew by now.

**The Chair:** We should, but sometimes we forget.

**Dr deVeber:** It's the main form of peritoneal dialysis that's done. There are four exchanges a day and it takes about half an hour to do each one.

You can see that a considerable number of patients were lost to death and some were transplanted, coming around the clock counterclockwise. But the most important thing there is that 22% of those patients, or almost a quarter of them, changed the modality for one reason or another. The next pie chart looks at why those 441 patients, taken from the 2,000, actually changed.

If you go back up to 12 o'clock again, there were various medical reasons which we couldn't do much about. You'll see, coming counterclockwise, that 31% were lost to peritonitis. That's 1990 data, and I would say that number would be much less now with new developments in technology, but it's still a problem. The next one is catheter infection or a loss of catheters. Again, another problem which is probably getting better.

But the most important thing is to look on the right

side where we see that 33% dropped out and had to go to haemodialysis, which, as you'll see in a minute, is a more expensive therapy, because of psychological or non-compliance reasons or, in the green, because of inadequate dialysis.

Psychological would imply that a person basically didn't like the routine of changing the bag four times a day; they weren't willing to go to that much trouble or they'll do it for a while and then they get tired of it. So they decide they'd rather go and have haemodialysis, where they can go to the hospital three days a week and just get taken care of by somebody else.

Non-compliance would be something similar, in which patients, instead of doing four exchanges a day or the number they're supposed to do, may drop an exchange because they don't want to spend the half-hour it takes to do one and they go eight hours, instead of four and six hours, or 12 hours.

In terms of inadequate dialysis, there are really two reasons for that. Sometimes people are just too big to do peritoneal dialysis. The regular four exchanges just aren't enough and they need more than that.

Other patients have particular kinds of peritoneal membranes or cavities where the transfer of the poisons doesn't quite work well enough and they need more peritoneal dialysis or some other form. As time goes on, often, after two to three or four years, the membrane actually gets thickened and the transfer of poisons doesn't work well, so they again need more dialysis. Also, the native kidney function—the patients usually have a bit of kidney function when they start out and they lose that as time goes on, and that's a critical factor in how much dialysis they need.

What's been happening to all these people in the past is they've all been going directly to haemodialysis which is more expensive and for which there's no room, as you know.

I'm just going to go through the costs here and I'd like you to look at the bottom line. On the left is haemodialysis and on the right is peritoneal. Going across, you can see that these costs are everything except physicians' fees. It includes all the hospital overhead and costs.

Haemodialysis in the hospital is \$42,000 a year; self-care such as in the Sheppard Centre or the Sussex Centre or at the Markham private care centre would be \$30,000; regular CAPD, which is four exchanges a day done by the patient at home by hand, is just over \$20,000; using the new cyclor type of dialysis, which, as we'll see in a minute, is done at night, including the cost of the machine amortized over five years, is about \$25,000.

The point is that peritoneal dialysis is a cheaper form of therapy and, if we can find a way to keep more people on it, we can probably get more people dialysed per dollar. If you look at the bottom critical ratio or cost ratio to total care, you can see that it gets better as we go along.

Just to talk a bit about continuous cyclor or cycling peritoneal dialysis, it uses a cycling machine and generally the way it's done, instead of being done in the

daytime, the patient goes to bed at night and hooks up to this machine and it runs the fluid back and forth at a fairly rapid rate, so that the exchange rate of poisons is fairly fast. If you do that for seven or eight hours a night, six or seven nights a week, you'll get equivalent dialysis or better to the old way of doing CAPD.

#### 1610

I just want to show you, this is the first cyclor that Baxter brought out, or I guess it's the last one before the one we have now. You can see it's rather bulky and would do all the things you would ask it to do, but it weighs 125 pounds and it's not very portable, other than being pushed around a room. It really ties the patient to home.

Here is the latest version, which weighs only 22 pounds and should do all the same things and can be carried around or transported pretty easily. It's a pretty simple machine and can do cyclor dialysis at night quite easily and it's very simple to operate.

What cyclor dialysis means, if a patient can do that, first of all, there may be patients who, when they come along to start dialysis, might prefer being at home; one would think they would be. If they could do it at night and not have to spend a lot of time in the daytime doing dialysis, they might choose that. Some of the people who choose haemodialysis might choose this type of dialysis. It also would help the patients who are getting inadequate dialysis or, for psychological reasons, don't want to do CAPD. This way you can do more dialysis. You can speed up the cycles and you can tailor the therapy to the patient.

Just to look at the incidence of cyclor dialysis, it really started becoming popular about 1990. You can see that it's rising slowly. The main limiting factor at the moment is that the machines cost \$8,000, which is a capital equipment cost, and none of the hospital programs is funded for that; they don't have any capital equipment money. So a lot of hospitals probably would like to be doing more of this, but they just don't have the capital funding. They can get operating costs out of their hospital budgets. That's something that should be addressed.

I want to just show you an example of a rather, I think, important example of how well somebody can do on dialysis, period, and, in this particular case, on peritoneal dialysis.

We had a young lady called Suzanne MacLean, who was hoping on May 28 to set out on a journey from Vancouver across the country to St John's, Newfoundland. She's a CAPD patient and she's going to ride across the country and raise awareness for kidney disease and show that kidney patients can do it. I have another photograph of her here high up in the Rocky Mountains, where she's doing one of her baggage changes. She's on regular CAPD at the moment, but she's a very courageous young lady, so we'll look forward to her coming through Toronto.

That's the end of my presentation. We'll be glad to answer your questions.

**Mr Jim Wilson:** Thank you, Dr deVeber, for your presentation. Just for the record, I want all members to



know that Baxter Corp has a very large plant in my riding and we're very grateful for the jobs that it produces and the stability it brings to the local economy. I thank you for coming on behalf of the corporation to share some of your expertise with us.

I think one of the concerns I have, though, is that none of us is a nephrologist around the table here. I guess what politicians tend to look for with some impatience is solutions. I'm learning, through the process of these committee hearings, that solutions aren't as easy as one might have thought from the beginning.

You mentioned one recommendation, that hospitals aren't funded for the capital cost of cyclers. Do you have any other recommendations for us? You've been in the field for a number of years and we would like, at the end of these committee hearings, to come up with some succinct recommendations for the government to take action on.

**Dr deVeber:** I meant to mention, through all the years I've been doing it and working in dialysis and so on, the planning process around it has been pretty tragic when you think there's been really no proactive planning or long-term planning. I really don't think we have it now. What we really see is a reaction to crises and patchwork. One area starts complaining a lot, then they get so-and-so. I'm not saying the ministry isn't doing its best, but I just think it doesn't have a long-range planning procedure.

I would really recommend strongly that they look at BC and Nova Scotia, that they set up an agency or a group that really are experts and have ongoing expertise and that this involve the nephrologists and the various people, the stakeholders and so on.

That would be my major recommendation, really, at the moment. There isn't enough money to run the health care system, really; that's the problem. If you don't get dialysed, you don't survive. You can't deny dialysis to people. You can deny annual physicals or you can deny more elective forms of health care to people and say, "If you want that, fine, but you have to pay for it."

**Mr Jim Wilson:** Thank you for the suggestion. Perhaps Mr Gardner in research could undertake to find out—and perhaps, Doctor, you could be of some help—what is happening in other provinces, that the agencies are up and running in British Columbia, for example.

**Dr deVeber:** Absolutely. We'd be glad to provide that.

**Mr Jim Wilson:** That would be very helpful.

**The Chair:** I think as well, Mr Wilson, we may be getting information on that tomorrow. One of the presenters is going to be discussing what's going on in other provinces too, which may help.

**Mr Jim Wilson:** Great. In your chart that dealt with costs, have you looked at the model of the independent health facility? I notice you had self-care on haemodialysis, but it's not really self-care and it's not hospital-based; it's more what we generically term as a "satellite" independent health facility set up in Markham.

**Dr deVeber:** Private. Mr Holtzer, I believe, is here, over there. I believe it would be similar in the sense that

the patient has to be reasonably healthy to be dialysed there; you can't have critically ill patients or really sick patients. So it would be the same environment as, say, the Sheppard Centre.

I personally believe private enterprise can do it more cheaply than hospitals or even perhaps centres run by hospitals. It's just inherent in business that if somebody is in a for-profit institution or situation, they look at every nickel. They look how much the cleaning fluid costs and everything else. That's my own opinion. I've never had any experience running one, so I can't say that for sure.

**Mr Paul Wessinger (Simcoe Centre):** Thank you for your presentation. With respect to CCPD, I assume you must have some indication from consumers how they feel about it compared to, for instance, CAPD. Is there a clear consumer preference for the cycling process?

**Dr deVeber:** We're seeing that. I haven't really been out in the field and talking to patients as much. Perhaps Nancy Abbey, who I think is going to be speaking tomorrow, could answer that question. Have we had any preference, done studies on this?

**The Chair:** I'm sorry. We have to just keep to you today, Doctor. I think your suggestion is a useful one and perhaps, Mr Wessinger, you can follow that up tomorrow when we are going to be getting more information.

**Dr deVeber:** You can ask Ms Abbey tomorrow.

**Mr Wessinger:** Yes, I can ask that. With the cycling process, you believe that more patients could remain on that process for a longer period than on the CAPD process. Is that correct?

**Dr deVeber:** The big problem with CAPD is that a significant number of patients have what's called technique failure. They're doing—well, they aren't always doing well medically, but they either don't like it or with the technique of CAPD, which limits you to four exchanges a day or four bags a day, they don't get enough dialysis, whereas with cycler dialysis you can tailor, you can give them as many bags as you want. It depends how fast you run the machine. If you use more bags, it costs more money; that's the only thing. But you can take somebody who's not getting enough dialysis on CAPD and put them on cycler dialysis and provide enough. That's the message.

**Mr Wessinger:** I understand it just needs to be done once a day. Is that correct?

**Dr deVeber:** Basically, most patients will do it overnight. They just hook themselves up before they go to bed and they turn the machine on. The machine cycles the fluid back and forth all night and the patients don't really feel that. It doesn't keep them awake or anything.

1620

**Mrs Sullivan:** I'm interested in the best-demonstrated-practice data that you have here. I wonder if you could tell the committee, first of all, if anyone who would qualify for the CAPD would also receive the same recommendation for treatment by CCPD.

Secondly, I'm looking at the direct cost comparisons between the two modalities. Are there any other costs associated with drug use that might alter those figures, or



other responses or complications that may affect the client response?

Thirdly, and I think Mr Wessenger touched on this issue, would there be lifestyle, quality-of-life factors that would mean that if a patient were going to select the appropriate modality, the patient would in fact choose the continuous process rather than what appears to be a more cumbersome process that interferes with their activities of daily life?

**Dr deVeber:** In answer to the first question, anybody who qualifies for CAPD theoretically should be able to do CCPD. Secondly, there are no additional drug costs that I know of. Thirdly, because somebody coughed, I didn't quite hear the question, but did you ask if people might choose that over haemodialysis?

**Mrs Sullivan:** No, if they would choose CCPD over the CAPD. From your experience, if it were a question of patient choice, because of, I suppose, the more beneficial routine associated with the dialysis, would the patient select the continuous process?

**Dr deVeber:** I would think so, and that's a question that was asked, I think, before. I haven't had a lot of field experience, as this is a relatively new type of dialysis, but it seems logical to think so. Most people would rather go to bed and have something done when they're asleep. When you're on CAPD, if you're working, when you're at work you have to go into a special room or a washroom and do your exchange. It takes half an hour four times a day, which is two hours out of your day, basically.

**Mrs Sullivan:** How broadly based would the CCPD be?

**Dr deVeber:** I think it's being used across the country. Somebody out there said there's a lot of it being done in Vancouver. There's a big program in Kingston. You heard last week from Dawn Evans from Kitchener on the new cyclor program. The Toronto Hospital, as I understand it, is just getting it. They're taking those patients who would have gone on to haemodialysis, where there's no room, and finding a way to deal with them, or many of them.

**The Chair:** Dr deVeber, thank you again for coming, both for the slide presentation and also for the written document you've left with us.

#### NORTHERN DIABETES HEALTH NETWORK CORP

**The Chair:** I call on Mae Katt, the vice-president of the Northern Diabetes Health Network. Ms Katt, welcome to the committee.

**Ms Mae Katt:** I have prepared a written submission that I believe was circulated to you. I'm also happy to be here this afternoon to share with you what we're doing in northern Ontario.

We certainly have some critical issues related to kidney dialysis, and more specifically related to our role as the Northern Diabetes Health Network Corp, where we have numerous board members spread across northern Ontario from the Quebec border to the Manitoba border, up to Sioux Lookout, Attawapiskat, Moose Factory. I think our north begins at Parry Sound.

I have prepared for you some of the barriers that we

are experiencing with the management of clients with diabetes and those receiving kidney dialysis.

The mission of the Northern Diabetes Health Network Corp is to ensure that people with diabetes and their families in northern Ontario have reasonable access to programs and services for the enhancement of their quality of life. We do this through complementing what already exists in hospitals and communities, and we create new programs especially to serve our difficult-to-serve clients due to the rural geography that we have to deal with or our aboriginal and francophone clients.

The development of the Northern Diabetes Health Network is kind of an innovative approach. We were initially supposed to be an advisory committee to the Ministry of Health. Knowing that living in the north sometimes presents an opportunity to be creative, we took that opportunity and incorporated. We do report financially to the Ministry of Health, which provides our funding, but our accountability is also to our members, our projects across the north and the people we serve.

Our objectives are to improve consumer access to comprehensive and coordinated ambulatory diabetes services, to improve the health status of northerners, to achieve health equity, which is often very difficult to define, and to create a sense of community empowerment.

The 22 board members have reviewed proposals over the past year. We have allocated \$4.92 million to 35 diabetes programs or projects throughout the north. For the member who's just left, I guess, we have a total of 35 projects; we have 21 projects in the northeast and 14 projects in the northwest. Our northwest-northeast division is around Sault Ste Marie.

What we try to achieve is basically looking at how we do screening, how we do early intervention, early treatment, that our client and family education is appropriate and that we have access to community-based services to prevent end-stage renal disease that brings our clients to having to use kidney dialysis. We've found that 30% to 40% of clients with diabetes will over a period of years with diabetes, usually after 15 years, become candidates for renal dialysis.

With regard to our dialysis services in the northeast, for a breakdown to show you, we are fairly busy in the northeast with 265 clients; 50 of these clients are receiving haemodialysis. We have probably our largest number of satellite centres in northeastern Ontario, the primary site being Sudbury's Laurentian Hospital, which works closely with southern Ontario facilities, especially in the treatment of children.

We have Parry Sound, which has four clients on haemodialysis; Manitoulin and Espanola have 12 clients; Kapuskasing with four; Timmins has 12; New Liskeard, four. We couldn't get the exact numbers from Sault Ste Marie, Kingston and North Bay. Kingston was a little more difficult, because the clients are being referred in from the James Bay Cree communities, and because it's a federal service, we had difficulty getting exact numbers.

When we start dialysis, the clients come to Sudbury for two weeks and then they are followed at the outreach

sites. All changes in treatment, any kinds of changes in condition, all those changes are done through the physicians in consultation with specialists at Sudbury.

In the northwest, we have a slightly different picture. In Thunder Bay, we have 41 clients receiving haemodialysis at McKellar General Hospital and 25 to 28 receiving peritoneal dialysis. We have one satellite in northwestern Ontario; that's in Sioux Lookout and it's brand-new. I think the opening is on April 29. You're certainly all invited to attend. Fifteen clients are on haemodialysis there and 10 are receiving peritoneal dialysis.

In Kenora, we have six clients who are on haemodialysis; they only do haemodialysis there. The Kenora situation is quite interesting from the perspective of the board. When we had talked to the Winnipeg Health Sciences Centre last fall, they were a little concerned that we were going to steal their clients from them, because we were setting up projects throughout the north. Now the picture has changed a little bit, where they're starting to say, "No more," to out-of-province clients.

We're a little concerned because at McKellar hospital we have no more space for dialysis; in Kenora we're at full capacity as well as at Sioux Lookout. They want to transfer 10 to 20 clients back to Ontario. The Lake of the Woods District Hospital in Kenora is a satellite centre of Winnipeg. Looking at the history of that, in 1991—I don't know what environment politically we were in at the time, but that's where the province of Ontario transferred money to Manitoba to run the program in Kenora.

1630

In Sioux Lookout we have the satellite centre, with 20 to 25 clients on dialysis. I just want to illustrate some numbers for you in looking at what we're dealing with. In Sioux Lookout we have a registry of 1,000 clients. Most of those are aboriginal clients who are coming in from 28 isolated communities in the north.

When we look at the numbers—I have provided a table for you to look at the number of years that these 1,000 clients have had diabetes—in terms of when they've been diagnosed, for zero to five years, we have 550 of them who are almost new diagnoses; none of them is on dialysis at present. For diagnoses in the last five to 10 years, we have 220 clients, and none of those is on dialysis. For those who were diagnosed in the last 10 to 15 years, we have 120 of those, and none of those is on dialysis. Of all our clients, 15 of the 110 who have had diabetes for over the period of 15 years are the ones we now have on dialysis.

Based on this population sample, we can almost make a prediction that in the next 10 to 15 years we're going to have 115 additional clients requiring dialysis just from the aboriginal population.

From the standpoint of board members and those who've done a lot of community work, knowing that we would rather stay home than come to cities—some of you don't understand that, but that's the way—

*Interjection.*

**Ms Katt:** I think when you look at children who have to go to Ottawa, who have to come down to Sick Kids,

there's certainly a real disruption in family life, in the kind of additional stressors, economic stressors, that are put on the family. We think we can improve services through the Northern Diabetes Health Network.

Our mandate for funding is ending at the end of March 1995. We've received \$5 million. We developed for the first two years. This is the first year that we've allocated the \$4.92 million to programs. We hope our mandate would be renewed. We think we're doing some good work. We're certainly doing some early screening and some early education. We're seeing some very good outcomes from patient compliance. We're seeing some very good outcomes from a psychosocial standpoint, in terms of how our clients cope and deal with something like a new diagnosis such as diabetes or a progressive disease like kidney and renal failure.

In terms of recommendations, we'd recommend:

(1) That we look at improving our screening and our early treatment. We can do that in cooperation with the existing health system.

(2) That we look at services that are locally provided through such a system as the diabetes health network.

(3) That one of the strong points of our delivery is that we are culturally and language-appropriate for aboriginals and francophones. We have three or four native dialects that we provide service in throughout our 35 projects.

(4) That one of the areas we heavily rely upon and would certainly love to have as part of our delivery would be specialists such as the paediatric nephrologists, the ophthalmologists and the endocrinologists.

(5) That we'd like to see more treatment spaces through satellite centres. I think there's certainly room in the northwest for looking at satellite centres in Fort Frances, Kenora, Dryden, places like that.

(6) That when we're looking at the low health status of aboriginal people, we certainly have to look at the availability of certain services. Because of our lack of running water, we can't run the peritoneal dialysis that was discussed earlier. We tried it in one community last year. We sent up fluids and the fluids froze. It was basically garbage after that. In terms of looking at improved public health services to aboriginal people, they are at greater risk for nephropathy and they certainly do have substandard living conditions.

(7) My last one is a pitch for money. Again, it's to get to the renewed mandate of the Northern Diabetes Health Network. I think we're a committed group of laypeople who are volunteering our time to provide a service, provide some direction and certainly be advocates for northerners.

The last page that I have is basically a summary of our barriers to treatment that I've already covered. I guess the only one that I didn't really talk about was cost from a system point of view. We know that from an individual perspective our clients do incur financial hardship, that the northern travel health grant is usually not enough money. Certainly being away from home for six months is a cost to somebody. So in terms of system costs as well as individual costs, we know that more local, community-based treatment could probably save some



money. Thank you for your attention.

**The Chair:** We are running a bit late, if people could keep their questions short, sharp and direct. We will begin with the usual short and sharp Mr Wilson.

**Mr Jim Wilson:** Mr Chairman, you're too kind.

I want to thank you for a very interesting presentation. It really follows on the heels of some comments that were made to this committee last week about aboriginal peoples. We had a physician tell us that because of the lack of community-based services, a number of aboriginal people—he couldn't prove it, but he said they must be deciding to die rather than go to the cities for dialysis treatment. Statistically they couldn't figure out, apparently—there should have been more aboriginal peoples in dialysis in the urban centres, given that they know, statistically anyway, the onset of kidney disease.

Have you had any firsthand experience that people are just giving up rather than travel to the cities?

**Ms Katt:** I don't think people are giving up on life. I think part of our culture is a respect for life. I know that in many ways we get very despondent about having to be torn away from our communities and our families. What I do know is that with better screening we are certainly finding clients with diabetes much earlier, which means we're not getting to that end-stage renal disease as quickly.

We've had kids run away from dialysis units and go back home. We know they get sick. We have been able to respond through other ways, like the satellite centre, placing them in Kenora. I don't think there's really a conscious decision being made of that.

**Mr Jim Wilson:** A quick question: The Northern Diabetes Health Network: What is your relationship with district health councils?

**Ms Katt:** They were involved in our development. They are certainly, as ex officio members, on our board, and were good advisers in terms of the regional planning perspective and how we fit into that.

**Mr Jim Wilson:** Is there planning going on with respect to future expansion of dialysis services in your area?

**Ms Katt:** We're waiting for the evaluation of our projects. We're just putting in an evaluation process now. I know that with the Manitoba movement we're certainly a little anxious about where we're going to place 20 people.

1640

**Mrs Sullivan:** I'm delighted to see Ms Katt again, having discussed northern health issues on other topics on other occasions. I know her sensitivity to the delivery of health services in remote areas.

Dr McCready from McKellar Hospital was with us the other day and spoke about what he saw as the success of some of these satellite centres, and the requirement that specialists from the hospital-based facilities travel to those centres to ensure that the patients are seen from time to time.

Do you have any sense of whether there are adequate visits to the satellite centres and whether there are

inadequate numbers of people who are trained in gauging patient response to dialysis? Does it have to be, by example, the nephrologist who attends the satellite clinics? Could there be another practitioner who might be useful in those situations?

**Ms Katt:** I guess we see specialists for two main functions. One is to educate the physicians and the care givers who are there, certainly the nursing staff who have to look for certain changes in health status and behaviours of the client. Certainly, that teaching role is one of the primary functions for a nephrologist, to do some client case conferencing, to do some work such as that.

In terms of the nephrologist doing the actual client management, direct hands-on care, we don't really see the need for that as much as long as they're there for consultation. So I think our physicians are quite open to ongoing education.

Where we look at other kinds of specialists, I guess, are the ones who can deal with native people, who can do some diet education in Ojicree. Those are the kind of specialists we really need to build as a foundation so that we always have the ongoing diabetic educator.

**Mrs Sullivan:** I think that if we're looking at needs-based planning, the data Ms Katt has brought to the committee is very clear. The incidence of diabetes and the consequent effect on end-stage renal disease just follows a pattern.

Also, Mr Chairman, I wonder if we are having anyone else to speak on child dialysis and nephrology. This is the first time that children, I think, have been raised in our hearings.

**The Chair:** I don't know that we have anyone who is specifically on that. It may come up. Perhaps one of the presenters tomorrow is going to be speaking on that.

**Mrs Sullivan:** Then we might just want to underline the distance factor for northern Ontario children.

**The Chair:** Mr Wessinger, if you have a question of Ms Katt, perhaps you could put that quickly, please.

**Mr Wessinger:** Thank you very much for appearing today and particularly bringing to our attention the fact that the rate of end-stage renal disease is increasing much higher for the aboriginal peoples than it is for the Canadian average. I guess the clear indication of the importance of your diabetes network is because diabetes is the major factor in that increase.

There's one statistic here I was curious about, if you have any explanation. In northeastern Ontario, I noticed you have 265 clients receiving dialysis, of which 50 are haemodialysis, which would mean that the vast majority are on peritoneal dialysis. Is there any particular reason? Is that a matter of choice of the consumer or the fact that haemodialysis is not available to the people in the north?

**Ms Katt:** I guess it is part of client choice. We don't have the equipment to do a lot of haemodialysis, where it's much cheaper to do peritoneal, although you have to have the facilities: the running water, the storage capacity for the fluids. But I think for most clients, doing haemodialysis and having a noisy machine all the time is a little intimidating. So I think if I had a choice, I would go with the peritoneal.



**Mr Wessenger:** Yes, the peritoneal would also allow it to be done in-home too.

**The Chair:** Thank you, Ms Katt, for coming today and for the statistical data you brought to us. We appreciate it.

PETER BLAKE

**The Chair:** I call on Dr Peter Blake, the vice-president of the Ontario Medical Association section on nephrology. As Dr Blake is coming forward, committee members, perhaps we could be aware of the time.

Dr Blake, welcome to the committee. A copy of your remarks is being circulated. Please go ahead once the machine is, hopefully, working.

**Dr Peter Blake:** That's probably too small for you to see but you all have a handout, in any case.

First of all, thank you very much, Mr Beer, for inviting me to come to your committee meeting. I think it's a very important committee and I'm very glad to attend.

You've probably heard a lot from a lot of nephrologists at these committee meetings, and I haven't been present and I hope I don't repeat too much today that's been said before, but I've tried to lay down in this presentation what I think are the essential points of the problem at the moment and some suggestions. I'm not speaking here for the OMA or the OMA section on nephrology. They're essentially personal opinions, though I think many of my colleagues would share them.

I would like to say first what I don't think can be said often enough, that dialysis is a very unique and special treatment. There are approximately three quarters of a million people now on dialysis around the world. All of those people would not be alive if it wasn't for dialysis. The enormity of that is sometimes forgotten. The discovery of dialysis is analogous to the discovery of insulin or other equally important advances in medicine. There are 7,000 people in Canada on dialysis and 7,000 more who had transplants who did spend time on dialysis. So this is really a very wonderful treatment. It doesn't restore normal quality of life, but it's a lot better than the alternative.

I've tried to sum up here in 10 quick points, and you probably are aware of some of these, where this problem is coming from.

There's a 7% increase every year on average over the past five years in the number of patients receiving dialysis in Canada. The main reason for that is not so much that kidney disease has been increasing, but that older patients who previously had been allowed to die because they were perceived as too old or too sick to receive this treatment are now being accepted for it and being kept alive on it. The other obvious factors are that the population is actually increasing anyway, the general population, especially in Metro Toronto; that's a big factor. The population, as we all know, also is aging and kidney disease is mainly, though not only, a disease of older people, so there's an increase for that reason.

For all these factors, we're seeing this consistent increase. It's not exclusive to Canada. It's being seen in the United States and indeed right across the developed world. It's a universal or worldwide phenomenon. There's

no sign at the moment that it's levelling off. Presumably, eventually, it will, but there's no sign of that at the moment and we must presume at least for the next couple of years ahead that it's likely to continue.

Preventive strategies are always very attractive. Prevention is always better than cure, but I think we have to remember that prevention usually isn't a quick fix and it may take 10, 20, 30 years to see the benefits of preventive measures such as you've been hearing about from the last speaker—better control of diabetes, better control of blood pressure. It's not going to be a quick solution.

Kidney transplant was once felt to be the solution to this problem but kidney transplant rates have not increased proportionately, as you've probably heard, with the increase in the number of dialysis patients. In any case, even if more kidney donors were making their organs available, it wouldn't solve the problem because two thirds of our patients at the moment are not medically suitable for a kidney transplant. By that, I mean they're either too old or have too many other medical problems to be a good risk for the extensive surgery and medications that are involved in getting a kidney transplant. So even if we had all the kidneys in the world, two thirds of the patients still would probably need to stay on dialysis. That's an approximate number.

I think we do have some scope, however, having said that, to increase the transplant rates. Our rates have not increased despite many efforts to do so. I think the sort of things we need to consider again are things like presumed consent, which is practised in some European countries; in other words, an opt-out system, where instead of signing your driver's licence to say you will, you have to sign a driver's licence to say you won't, and the absence of a signature is taken to mean that you're saying yes. The alternative is incentive fees for hospitals as is now being practised with some success in the province of Quebec, where hospitals are provided with incentives to make sure that suitable donors' kidneys are actually harvested, and this seems to work.

1650

Moving on to rationing of dialysis, I think it's generally felt that this would not be acceptable to Canadian public opinion. It certainly wouldn't be acceptable to individual patients and their families when they have the problem. Therefore, we have to think in terms of 5% to 10% expansion, the numbers of patients on dialysis, going on at least for the next number of years.

Having said that, the most expensive form of dialysis, as you've heard this afternoon, is in-hospital haemodialysis. Therefore, if we've got to look for some solutions, I think it would be cost-effective to maximize the number of patients doing other forms, which I'm loosely calling self-care dialysis. That's either self-care haemodialysis, as in the Sheppard Centre, or home haemodialysis, as in the patient does it himself in the home or peritoneal dialysis, be it the standard CAPD that you've heard about or the cyclor dialysis that Dr deVeber talked about.

We have to keep in mind, and not everybody will agree with this, that perhaps 40% of our patients at the

moment are not capable of doing any of these self-care techniques as presently constituted. They are either too infirm or social circumstances do not lend themselves to their doing a form of self-care dialysis. They need to have it done for them.

Having presented the problem, I'm going to draw some conclusions and try and make some suggestions. The first one is the obvious one: Everybody wants more money. There's no escape from the fact that programs are going to continue to expand, and unless we introduce rationing, which I don't think is acceptable, somehow there's going to need to be more funding for dialysis. I know that's a problem, but I think that's the reality.

With regard to transplant, I think we need to look at trying to increase the rates of transplant and to consider things like presumed consent as incentives for the hospitals to retrieve donor kidneys. If we do that, though, we have to remember that there has to be a sensitivity. Any measures that would appear to be coercive to the Canadian public, to the relatives of potential donors, might have a very negative effect, so this has to be done very carefully. There should be no hint of coercion.

A third point is that we need to consider some sort of incentives for renal programs to maximize the number of patients on the more cost-effective, self-care dialysis modalities. In other words, there should be some incentive built into the system to encourage hospitals not to have everybody in the most expensive in-centre treatment and to encourage them to have more people on self-care modalities, whatever type you choose.

We also need to look at perhaps introducing some sort of modified forms of self-care. I've already said that about 40% of our patients at the moment are incapable of doing self-care as constituted because, for example, if you do self-care haemodialysis, you have to come an hour in advance and you have to prepare your own machine, which is not a simple thing to do. You have to be quite mechanical and be quite bright to do that. Then, in many cases, you have to put your own needles in, which is a difficult thing for many people to do.

I wonder sometimes if we introduced modified forms of self-care, intermediate between the hospital intensive in-care type of haemodialysis and the existing self-care, whether we would be able to take more patients out of the hospitals and put them on self-care. In other words, there would be a lesser degree of staffing than in a hospital but a greater degree of staffing than in some of the existing self-care units. I think if you take these treatments outside hospitals, they often become less expensive.

The point has been made already that we need to move from the crisis management system which we're sort of in at the moment to some sort of planning. Dr deVeber mentioned that. I think it's a very important point and other provinces, which you're going to hear about I understand, have taken a move that way.

One more point I'd like to make is that independent health facilities were mentioned earlier this afternoon. I think that may become a big issue. It's very important that we maintain standards. Canadian dialysis units are very well run. It's generally felt that the standards of

medical care are much higher than in the United States. The reason for that is that many of the units in the United States are private units where there's very much a need to make a profit, and therefore there's a tendency to cut costs. This is admitted by many American nephrologists and commentators on American health care.

That doesn't happen in Canada at the moment to any significant degree because we don't work that sort of system. If we introduce any sort of independent health facility where that might be the case, it would be very important to ensure that the present high standards of care in dialysis units are maintained, proper standards are laid down and there's proper supervision of those units.

The last thing: I work in London, in the southwestern Ontario region. One of my colleagues will be speaking tomorrow in more detail about this, but I should just point out our problems. I'm dealing with a region here of 1.4 million people, including Windsor and London.

We have 420 patients on dialysis in that region, which puts us pretty well at or even slightly above the national average. Most of them are receiving their care out of hospitals in London, but there's also a hospital in Windsor giving dialysis. We run satellite self-care units, because of the long distances in that area, in Hanover and Sarnia. These, I think, perform an important role. Overall, we have 41% of the patients in the region on self-care dialysis modalities and we're attempting to increase that.

Two years ago, we had a very welcome expansion in Victoria Hospital, the biggest institution in the region providing dialysis, and that temporarily took the pressure off us a little bit, so we have not been as badly off as Toronto. Unfortunately, that unit is now filling up, and like everybody else, we're likely to be looking for help to fund the inevitable expansion that's occurs in the coming years.

**Mr Wessenger:** Thank you, Dr Blake. I'm trying to look through some of the various statistics here and one of the things that seems to come to light is that there seems to be quite a variation, depending on the region, on the number of patients in haemodialysis and peritoneal dialysis, and it was suggested by one of the presenters today that you could in effect have 85% of the client population on either one or the other as a matter of choice. Is that a fair reflection?

**Dr Blake:** I'm a great admirer of Dr deVeber. He's a former mentor of mine and I'm also involved very much in peritoneal dialysis, but my personal opinion would be that 15% is a little low to state the number of people who don't do peritoneal dialysis well. I would put it higher.

I think that many of the older patients we see have great difficulty doing it because of their general infirmity. Unless they have a relative who's prepared to do these four exchanges a day with them, it's very difficult. Perhaps with the cyclical modalities, some of these people will be able to do peritoneal dialysis, but in my experience that's difficult for many of them. Personally, I would think it's a little higher.

You're quite correct: The regional differences are quite marked. That reflects, I think, the interest of the physicians. For example, Toronto was one of the centres



where peritoneal dialysis was first popularized for all of the world. Dr Oreopoulos's work was pioneer work here. Inevitably, it became a centre for that and now we have over half the patients on it in Toronto. I suspect that's too many.

The worst thing that can happen from a cost-effective point of view is that a patient is trained to do this peritoneal dialysis and then fails within a few months. If your patient selection is not careful, you make a mistake and the patient goes on the wrong treatment, then you've to take him back and start all over again.

It's clearly been shown in studies that this is the least cost-effective way to practise dialysis. Get it right the first time and avoid switching modalities is a very good policy. Toronto has not had that luxury recently and they've tended to put people in peritoneal dialysis and then they have higher failure rates as a result.

Perhaps one more point about the regional issues: London, where I work, has had less people in peritoneal dialysis and sometimes is criticized for this. Again it's a tradition in a sense. London was a relative pioneer in Ontario in terms of satellite and home haemodialysis and built up big programs. When you build a satellite unit, as we have in Samia or Hanover, you need to keep patients going into it; otherwise it becomes cost-ineffective. There's nothing worse than having a unit and putting all the people in the town on peritoneal dialysis when you have a unit there. You should use the unit as well. So economics comes into this too.

**Mr Wessenger:** With respect to self-help dialysis or doing it yourself, is there much difference with respect to training someone to do their own self-help haemodialysis as compared to doing self-help peritoneal dialysis in their home?

**Dr Blake:** There's a big difference. Peritoneal dialysis is a fairly simple thing. You can teach most people to do it—some people in as little as two days; some people take seven to 10 days, that sort of range—and you can teach people who are not particularly mechanical to do it.

Haemodialysis, on the other hand, to do self-care haemodialysis takes perhaps four, five or six weeks to train them, so it's a lot more time. If you want to train them to do dialysis in their own home without any supervision, it's even longer. There's a big difference.

**The Chair:** Thank you, Dr Blake, for the way in which you've set out both the issues and your recommendations. It will be of great help to the committee. I believe two of your colleagues are going to be here tomorrow.

1700

ELI RABIN

**The Chair:** If I could then call on Dr Eli Rabin, senior nephrologist from the Ottawa Civic Hospital.

**Dr Eli Rabin:** Mr Chairman, thank you very much for inviting me to speak to you today. I apologize for not having a prepared report, since I just returned from meetings overseas, but I will submit one to you within a few days.

I guess we're the victims of our success. As Dr deVeber pointed out, he and I began in the very early

1960s and it has now led to a very large population of people being dialysed at the present time.

However, I'm here to talk about our successes rather than the doom and gloom that I sort of hear around the table. Approximately two years ago in Ottawa we were faced with the fact that our unit was full. The Ottawa General Hospital and Ottawa Civic Hospital were both approaching being filled and so we had to look at what we could do with our patients.

We discovered that large numbers were coming from up the valley and many were coming from the Cornwall area. We approached people within Renfrew county and, with very strong support from that area, came to the ministry. Within a short period of time, we were able to establish a dialysis unit in Renfrew, Ontario.

There are 16 patients currently receiving treatment at Renfrew Victoria Hospital. The care is being supplied by both nephrologists and general practitioners, which is a general departure from care in the province of Ontario. As a result, we have saved \$60,000 a year in travel costs for these patients, when they used to come from the valley down to Ottawa. We've also saved them from the perils of travel down the two-lane highway in the wintertime. We've also established a kidney clinic in the Renfrew area, where we pick up patients very quickly and treat them and try to prevent the progression of the renal disease to end-stage renal disease.

The Renfrew unit has been extremely successful. Since August 18, 1993, when it opened, until today, there have only been six occasions when patients have come from Renfrew down to the mother unit in Ottawa, and most of these were very simple problems dealing with what's called access, that is, when you have an area in the arm where you have to put needles, where a patient has access to a machine.

In summary, the Renfrew experience has been extremely positive. We had very good help from the ministry in establishing this unit. Unfortunately, however, our projections were entirely accurate. That is, within two years from the time we began planning and within six months from the time that we began dialysis, they were filled up. Now the logical thing is to come to the ministry and say we require more money to expand the Renfrew dialysis unit since there are now four patients on the waiting list up there.

The other point about a small-community dialysis unit is that there is tremendous support from the community for dialysis. The Legion made a commitment of over \$150,000 for a five-year replacement period of equipment. The grass-roots support for dialysis in small communities is absolutely fantastic. When you go out to these small communities, they're quite willing to put in as much help as possible. Unfortunately, when you ask many members from outside the major urban centres to contribute, from the outer reaches down to the urban centre, you don't get that same level of support.

Renfrew has been an excellent success story. I just wish to congratulate the ministry for seeing this project come to fruition. However, the story doesn't end there. The Ottawa General Hospital is now filled, the Ottawa Civic Hospital is now filled and the Renfrew Victoria



Hospital is now filled. Where do we go from here? We have a number of options. One is that we can begin to use the existing units to their full capacity and begin to have overnight dialysis.

As you know, dialysis is done on three shifts a day, from 7 o'clock in the morning till 11:30 pm. You can open up the unit from 11:30 pm overnight and have another shift, and therefore you can accommodate more patients. This, of course, is labour-intensive and requires a large amount of investment in terms of personnel. You don't require, however, the investment of a new building. You obviously will require some new machinery.

The next thing is that in terms of what you can do to increase the ability to handle more patients, you can look at other alternatives. One has to look, at the present time, at independent health facilities as an alternative to take the load of patients out of the existing tertiary care hospitals.

The tertiary care hospitals, because of the fact that most of them are filled up, end up playing a roulette wheel game in the sense that, when you're filled, you have a great deal of difficulty slotting patients in for dialysis. As a result, you have to start doing dialysis after 11 o'clock at night or after midnight and then you run into overtime costs, which become substantial. This happens, unfortunately, at least once or twice a week, and I am told at the present time we are over budget because of these problems.

If you have an independent health care facility where you have a stable group of patients, where the budgetary considerations are quite predictable, you can now begin to offload the "stable" patients into these facilities; you can now look after the more acute problems and the sicker patients within the tertiary care hospitals for which they are designed.

I think, when I looked at the mandate, it talked about commitment and I have no doubt about the commitment of the Ministry of Health. In terms of the priorities, who knows what everyone's priorities are? However, there is one statistic you should be aware of that was recently published: it cost between \$40,000 to \$42,000 to keep a prisoner in a federal prison, whereas it cost over \$70,000 to keep someone in maximum security in the federal prisons.

Some patients on dialysis would consider that they are in prison when they are on haemodialysis, and I've tried to say to them, "Well, it's not quite as bad as all that." Many of them are quite thankful for the generosity of the citizens of the province and the country that allows them to have their lifesaving treatment go on. They always hope that the priority within the population would be towards them, obviously, because their life is at stake, and they have instructed me to tell you that they hope you will continue with this priority for them.

Our problems are very difficult. As Dr Blake mentioned, we have an aging population. All of us, when we reach age 90, will have only 50% kidney function. Each of you sitting here is losing a little bit of kidney function every day, and if you have a little bit of kidney disease now, it accelerates as you get older, and that's why the aging population presents a major problem. If you add to

that the diabetic factor, you now accelerate the process even more. That is why we are seeing more and more patients coming to dialysis.

Also, the congenital disorders are now beginning to occupy a large proportion of our patients. Approximately 10% of our patients have congenital diseases for which we have no treatment or cure at the present time, and therefore the makeup of the population is such that we are being forced to take more and more people and we don't discriminate, obviously.

The transplantation numbers, as you've heard, are down because of the alcohol laws and the seatbelt laws. That's a good thing in terms of lifesaving laws; it's a bad thing in terms of not having enough donors for transplantation, and so this balance keeps going on and we try our best to retrieve as many organs as possible for transplantation.

In terms of cost reduction in the present units, there is one area where there is a major possibility, and that is by having altered labour categories within the system. In the United States, facilities are now moving towards phlebotomists and technicians rather than nurses.

I know this might be heresy and it might be anathema to many people, but instead of having one nurse per two and a half patients, you may have one registered nurse for four patients and have an altered class of labour looking after your patients for phlebotomizing them, that is, inserting the needles. This of course would require negotiations with hospitals etc, but that is one manner in which you can save money.

There are other areas where we could possibly save money, and that is to take a very hard look at how many tests we order on patients and how many drugs we use. Having mentioned drugs, there's one thing you can do for the patients on dialysis. Please put back the vitamins and the calcium on the drug list. For them it's absolutely necessary.

This is not a supplementation for them, where they buy an over-the-counter drug simply because they want to treat their arthritis or something like that. They need the drugs to prevent bone disease; they need the vitamins to put back the vitamins they lose during dialysis. Many pensioners can't afford these drugs and they don't understand why they were taken off. They don't know who gave the advice and why the advice was taken to take those drugs off.

If I can make one plea to this committee, if you can do something: Put the calcium and the vitamins back for the pensioners on dialysis. I think with that I will stop, because I don't want to exceed the time, and answer your questions.

**Mrs Sullivan:** Thank you very much. We are hearing fairly consistent issues from around the province with respect to the gap that's narrowing between the supply and the demand. We've heard information with respect to delaying the development, through screening programs and through other actions that can be taken; considerable emphasis on treating the patient closer to their home through satellite services and through services that, where possible, can be done out of the hospital; increasing the

number of transplants and the associated ethical issues that are included in that.

1710

But one of the things that we constantly hear is the need for a comprehensive program, a strategy, rather than the kind of crisis management that has existed. Today we've heard, I believe for the first time, the word "agency" pop out of somebody's mouth. We have just gone through considerable pressure with respect to the government on a cancer agency. I wonder if you'd like comment on the viability on an agency for kidney disease.

**Dr Rabin:** Agencies in general are probably a very good thing. The problem is that you may have competing interests on the agency and which region has greater influence within the agency versus another region. I think one of the biggest problems is that if you take a look at the Toronto area, it'd probably have much more clout than the area of Ottawa. It might have much more clout than the northern Ontario area.

I'd be very leery about agencies and their compositions and how they arrive at decisions, because in my experience there's a lot of lobbying that goes on and decisions are put out that are sometimes detrimental to the whole process.

**Mr Jim Wilson:** Thank you very much, Dr Rabin. I thought your presentation was excellent. I would disagree on one point. One of the reasons we're having these hearings is that I asked for them because of the lack of commitment from the Ministry of Health in this.

I happen to live in one part of the province that doesn't have any special designation. I'm not in eastern Ontario, so going to the Ministry of Health to get any special funding is extremely difficult. I don't live in northern Ontario, God bless them, but they've got 12 satellites up there. I live in the shadow of Metro Toronto, with patients who have to drive just as far as many of these other patients, and there's no special niche for my constituents and never has been, because our statistics are always shown in with Metro Toronto.

I've got people driving down dangerous highways for two hours, coming down here to Toronto. I've got a guy taking a bus, which one of these days he's just going to stop doing, I think. He's on the bus at 8 in the morning in Alliston and it's 8 at night before he's back at home. That's why, certainly in the central Ontario area, we think there is a crisis.

I assume by your discussion that a lot of those conditions existed in Renfrew before you got your satellite.

**Dr Rabin:** My suggestion to you would be to find a nephrologist from your area who may have grown up in your area or who has some sympathy to your area, from the Toronto area, and get him to work on your behalf. I don't know much about the Toronto organization in terms of nephrologists, but I know they sort of centre themselves around the teaching hospitals. Perhaps you may be able to find one or two of them who might be able to convince their colleagues that they do something for your region. The approach may be to have someone from your region who may be a nephrologist or closely allied with

nephrologists from there.

**Mr Jim Wilson:** I appreciate the suggestion. Just so you'll know, though, we've had public meetings there and both nephrologists have appeared. Dr Mendelsohn, for example, has been to the public meetings. Part of the problem is, and why Toronto hospitals are quite interested in—and have been very supportive, to an extent anyway—helping us out there in Simcoe county, is that they're getting tired of having our patients come to Toronto. We're clogging up their system is their view. I appreciate that they are trying to be helpful.

One of the frustrations I've had too is that I've watched as the member over the years, in Alliston, for example, and Collingwood. Let's just take Alliston very quickly. There was probably one machine there about two years ago; now there are three machines in the area—four if look just outside of Alliston—serving only four patients. We've got about eight more patients on top of that driving to Toronto.

It seems to me it isn't very cost-effective. Every time I complain, the response is—I managed to convince one hospital, anyway, in Toronto to give us a machine for patient X who just can't handle the ride any more. To me, that's just a stupid way of approaching this whole problem.

**Dr Rabin:** We do it the other way around. I and another nephrologist go up to Renfrew. Each of us goes once a week. We have three general practitioners who work with us. The patients don't have to come down. I don't know how far Collingwood is from Toronto and what the cost-effectiveness for a physician is. But certainly I think it's easier to transport one physician than it is to transport eight to 12 patients over that area. If cost is involved, that is something that the hospital boards, or however the financing works out, may have to look at to help you in that dilemma.

**Mr Jim Wilson:** The point is that we've got four machines in town, and a lot more patients than that who apparently do qualify for in-home haemodialysis. They're not allowed to use the machines that are already in town.

**Dr Rabin:** I don't understand why they can't use them unless the ministry says it won't fund the operating costs, and then that becomes the source of an application to the ministry to say: "We have backup for the care of these patients. Please fund these machines and fund the staff for the use of these machines so that we can service these patients."

**Mr O'Connor:** Certainly part of the committee hearings that has been beneficial for members of the committee to take forward some of the concerns that my colleague has is that we've had an opportunity ourselves to get a little bit better educated, and in going through some of the process, we've then been able to see where somebody has brought forward to us earlier today—Dr George deVeber, thank you for this here. You've been able to spell out, for example, the labour costs.

I guess some of the concerns that my colleague would have then, for example, when we take a look at some of the work that was done—I noticed your head pop up when I talked about this. I think it's important. But at the



same time, when you take a look at, for example, all the Legions that were involved in it, they come from a lot of different small communities like Chalk River, Deep River, Petawawa, Pembroke, Barry's Bay, Eganville, Cobden and Renfrew, which all would then of course go to the Renfrew Victoria Hospital.

What my colleague is suggesting is not that type of an approach, not the hospital-based type of approach. Is there not a way that we could look within the community and go to the community itself? When you take a look at these numbers, if we could develop a network that would allow us to use some treatments that we can get some volunteers to maybe help out in, then it's utilizing the machines that Mr Wilson is referring to within his community. I guess it's a little different approach, but still it's what we're trying to take a look at here.

**Dr Rabin:** Under the existing framework, dialysis is hospital based. Therefore, if you have some sort of dialysis network in Collingwood or wherever, it has to bear some relationship to a hospital in Toronto unless you decide to have that dialysis unit have a relationship to a hospital in Collingwood, which may be related to a hospital in Toronto.

The only way to establish that kind of a network is you have to relate those patients to a centre, either to a community hospital or to a tertiary care centre. You just can't willy-nilly, out of the heavens, say, "I'm now going to dialyse four patients up here," because my understanding is that the Ministry of Health requires some sort of structure, which is very good in terms of control of the type of treatment people are getting.

Be very careful when you look at costs. Sometimes those costs don't factor in hospitalizations which are necessary for, for instance, some patients on CAPD. When they might develop peritonitis or other problems, the hospital costs that they incur aren't necessarily added into the bill.

There have been many studies done, both in the United States and Canada, which compare the costs. Sometimes the costs for CAPD aren't that much lower than that of haemodialysis when you factor in the costs of hospitalization, because as Dr deVeber and Dr Blake pointed out, about one third of CAPD patients drop out, and as they drop out they get sick, they become hospitalized and they incur those kinds of extra costs. So the costs can be quite difficult to determine.

But if you want to establish a network, you have to get a nephrologist and you have to get a hospital net. Those two are principal in aligning themselves with a mother centre, or whatever it is, and then you establish that network.

I don't know how it operates here, but I can assure you in Renfrew it was very pleasant. The grass roots came to the rally, the Legion came to the financial rally of the community. Everyone worked together, got together and said, "We need it, we want it and we're going to support it." Within a year and half the centre was established, and it has been very successful. I think that is the message I'm trying to bring to you: You can be very successful, but you have to get your community behind you.

**Mr O'Connor:** I think that's what we heard when we heard from the chair for the central east regional study that's taking place right now, going out there into the community, developing some of that. Of course we also heard from the women from the north how in some communities in Ontario the process doesn't quite work, whether you're tied to a hospital or not; for example, the aboriginal community, where they don't have some of the very basic facilities.

**The Vice-Chair (Mr Ron Eddy):** Thank you, doctor, for your presentation. We appreciate it.

1720

#### MORE PROGRAM OF ONTARIO

**The Vice-Chair:** The next presentation will be by the executive director of MORE, the Multiple Organ Retrieval and Exchange Program of Ontario, Ms Cheryl Rosell. Welcome.

**Ms Cheryl Rosell:** I want to thank the committee on social development for the opportunity to address the group. The packages that were distributed for all the committee members include my report, as I'm reading it, and the footnoted references. I included them because these are not always easily accessible through other means, so it was easier just to get them for you right at the beginning.

I've also included a document called MORE Facts, which we've been distributing for Organ Donor Awareness Week, which in fact starts today. They provide the transplant and donor rates over the past three years and give you some idea of what those rates truly are.

The MORE Program of Ontario is a Ministry of Health-funded program established as a not-for-profit corporation in April 1988. MORE was established based on recommendations of a Ministry of Health task force in the early 1980s. MORE was to ensure fair and equitable sharing of organs—that includes kidney, liver, heart and lungs—among the five transplant regions of Ottawa, Kingston, Toronto, Hamilton and London. MORE was also expected to carry out both public and professional education to increase awareness about the need for organ donation.

First, I'd like to address our computer system. MORE established a state-of-the-art computer system for organ sharing which went live in 1990. This included capital grants for equipment purchases to assist the histocompatibility labs for testing. In the past year, with a special Ministry of Health capital grant, MORE has also added screens for testing by DNA matching as a way of improving the donor-recipient match. This adjunct will put Ontario in the lead in North America for organ sharing based on best match.

Each renal transplant program has assistance with entry of information about recipients by MORE staff who work in the transplant centre facilities. They are trained in providing ad hoc reports to the centre for review of graft survival, rejection episodes etc. They also provide reports for use in follow-up clinics. Transplant information clerks' activities are regionally modified based on the needs of the individual transplant program.

Transplant programs use the computer to establish



which patients on the waiting list best match donors. Sharing between regions becomes particularly necessary for a kidney patient who has become highly sensitized, meaning that unless the match is perfect, they have a high chance of organ rejection. Each donor is compared to all highly sensitized renal patients in the province to facilitate sharing. This sharing came about with the advent of the MORE computer.

The main thrust of MORE's educational effort has been to the health professionals. The Ministry of Health communications branch has assisted MORE with grants for special projects, including development of a slide and video program—and the video was overdubbed in eight languages, including Ojibway, since I heard that mentioned—and a new workshop has been developed for health professionals on approaching donor families.

In case you're wondering why we decided to focus most of our effort on the health professional, the reasons for that included that in MORE's public survey in 1991, which is included in your package, the survey demonstrated that most of the public are in favour of the concept of organ donation.

Also, there are several public agencies that currently provide public education on the need for organ donation, including the kidney foundation, liver foundation, local Lions Clubs and the Mutual Life insurance corporation, but MORE is the only agency that directly works with the health professional and the hospitals to increase their awareness.

Even with a positive attitude by the public, we all recognize that if a health professional fails to introduce the topic of organ donation to the prospective donor family, the donor will be lost. The ministry's task force report emphasized the need for ongoing education in hospitals. This was specifically identified by the donor hospitals as a need, and critical for increasing donor rates.

MORE's 1994 survey of family practitioners identified their reluctance to approach donor families and their discomfort with the grieving family. What we identified was that basically one third of the physicians were prepared to approach a donor family, but clearly two thirds were not. Generally, the results indicate that they were reluctant to approach because they were uncomfortable dealing with the grief of the family, and rather than seeing this as helping the family through the grieving episode, they saw it as an infringement on that grieving process.

MORE's early assessment of most hospitals was that they needed assistance with policies and procedures and their implementation before donors could be increased. From 1990 until now, we've been working on that.

Since the amendment to the Public Hospitals Act in 1990, hospitals now have their policies and procedures in place, with assistance from MORE's regional communication coordinators, or RCCs. These are registered nurses who work in communities across the province providing education.

In 1993 MORE had a pilot project of decentralizing the RCC position. It moved from a full-time position located in the city where the transplant program was

located to several part-time positions in the communities to assist with local organ donor awareness initiatives. An example of this can be seen at the Hotel Dieu Hospital in Windsor. Before hiring the part-time RCC there, they utilized the RCC located out of London. At that time they had zero or one donor a year. In 1993, in the last eight months, they had seven referrals and five actual donors.

While not every hospital is expected to experience this growth with decentralization, it does demonstrate that results can be achieved with a visible, ongoing education program within the hospital. At MORE it is recognized that if each hospital identified one more donor a year, the waiting list would be significantly reduced and, within two to three years, equalized. To achieve that result, MORE has to ensure ongoing visibility about organ donation within each hospital, not just the transplant centres.

The new workshop for health professionals on approaching donor families will be presented province-wide by these same RCCs for their co-workers. Health professionals carry with them personal feelings about death and organ donation when they make the request of the family. While these feelings cannot be erased, we hope to teach how best to accept them as personal feelings that should not be put upon the conscience of donor families.

In June 1992, then Health Minister Frances Lankin announced at the MORE annual meeting that there would be an expectation for MORE to audit donor activity and compliance with the 1990 hospital act regulation within the hospitals. This is being initiated during this fiscal year. MORE will be able to establish a hospital's donor potential and provide feedback to that hospital regarding its compliance. It is hoped that Oshawa General Hospital will be the pilot site for this initiative during the summer months.

Establishing the donor potential within Ontario will be a critical benchmark for the program. The report on comparison of deaths by brain trauma indicates the significant decrease in brain deaths experienced as a result of motor vehicle accidents, yet the number of potential donors should still be much greater than what we currently achieve. Our goal is to identify how much greater.

With these new initiatives MORE is predicting an increase in organ donor rates of 10% within the next 12 to 18 months. The other increase being experienced in renal transplantation is in living-related organ donation. This can afford the recipient a better match, a healthier organ and better results due to removal and transplantation done at the same time.

While the focus of the RCCs' educational efforts have been with the health professional, MORE has also been active in public programs. In 1992 MORE evaluated some of our activity with these results.

Media coverage of health issues has been intense during the last decade. The majority of stories concern fitness, heart and stroke problems, cancer and AIDS, issues which affect hundreds of thousands of people across the province. Organ donation and transplantation directly affect about 2,000 people in Ontario. The altruis-

tict act of donating organs, combined with the miracle stories of the results of transplantation, make organ donation and transplants a popular media topic, despite the relatively low number of people it affects as a health issue.

Budget restraints have prevented MORE from engaging the services of a professional media tracking company. Copies of organ donation and transplant stories in the print media are received through the RCCs, who monitor media in their areas, through the Ministry of Health press clips, which they provide to us, and through monitoring of the three dailies in Toronto.

This casual clipping service, however, still indicates a tremendous amount of coverage on organ donation and transplants. For example, over a three-month period in 1992, dealing only with the major dailies in the five transplant regions, there were close to 3,000 column inches of copy. The stories covered all areas of the donation/transplant process, including stories from recipient and donor families, ethical issues etc. To put this in perspective, each page of the Toronto Sun is about 60 column inches. That means that if we put all the organ donation stories for 1992 into one copy of the Sun, it would be about a 50-page edition without pictures.

1730

From September to November 1992 MORE monitored a number of television features in Toronto, Hamilton and Ottawa. During that time, there was a total of 60 minutes devoted to stories about organ donation and transplantation on news shows in these areas. This does not include coverage of these topics on the US-based shows.

Local television news is generally one hour long. Half of that time is taken up with commercials, weather and road reports, updates, promos, sports etc. This leaves 30 minutes for hard news, and about half that time is traditionally given to international and national stories. This leaves a 15-minute window for local and regional news: about 300 minutes during a month of broadcasts, or 900 minutes during three months. Organ donation and transplantation received 60 minutes of the 900 minutes, or a little more than 6% of the time allotted to something which affects really a small number of people compared to many of the other health issues.

If MORE had to purchase that television time at a cost of an average \$1,000 a minute, it would have cost the program \$60,000 and been prohibitive. Television producers point out, however, that news coverage is worth a lot more in that it is more likely to be watched. As we all know, during commercials the audience is likely to leave the television set or change channels.

I'd also like to address the issue of legislation. There have been a number of ideas suggested regarding changes to current legislation to increase organ and tissue donation. Even while I was here this afternoon, the most popular one of these of late has centred around something called "presumed consent." This assumes that unless someone has registered specific wishes against participating in organ donation, the organs and tissues will automatically be taken. This demands that each person have a complete education with regard to what they're not opting out of, in the language of their choice, and they

must be provided an easy opportunity to opt out.

MORE is in the process of completing an extensive document on this topic which includes a thorough literature review. We hope this will be available within the next month.

The major result of our study is that we need an in-depth study in Canada about Canadian attitudes towards this concept, and MORE hopes to undertake this research once we find funding. There are some countries with very positive results from presumed consent, and more of them with less positive results. Success was achieved generally in small geographical areas with homogeneous cultures, and this is not the picture of Ontario.

The Law Reform Commission of Canada recommended, when it looked at the various legislation, including presumed consent, that "the general express-consent model of tissue procurement from deceased donors should be maintained and strengthened, as a preferred model for public policy."

Whatever legislation Ontario has or whatever Ontario legislation is undertaken, the critical components are that it not include a method of opting out of making the request because of a grieving family and that there must be provisions for the regular audit of the efficacy of that legislation. The current legislation does not prohibit organ donation. It's that there is not a full utilization of the legislation that's there.

MORE has requested the inclusion on the new health care card of direction regarding organ donation. This would ensure information being distributed to those who do not drive and would provide the record for the hospital. While a driver's licence is not always retrieved upon admission to the hospital, we all know that the patient's health card is. This process of ensuring that a choice is made one way or the other is sometimes referred to as mandated choice.

We've also heard references this afternoon to the Quebec experience, and I'd like to expand upon that. You may have seen articles about the Quebec experience where they refer to paying referring hospitals \$500 per donor and retrieval hospitals \$4,500 to reimburse costs. To accurately evaluate this initiative within Ontario, there are a few facts to bear in mind.

Of the \$4,500 paid back in Quebec, \$2,000 of that is for irrigating solution that the hospital must provide. In Ontario these solutions are brought by donor coordinators and therefore are not an incremental cost that is borne by the hospital. When talking with some of the staff in the Quebec transplant program, they have identified that it's not the money that increased donation, but rather the promotion that went with the money.

While Quebec did achieve a dramatic increase of donors, to 106 in 1993 versus 66 in 1992, we also remember that their donor rate was 98 in 1991. In 1992 all provinces saw a decrease, including Ontario, although ours was not as dramatic. Since, all provinces have also experienced an increase in 1993, including Quebec.

What Quebec has needed and what we need to observe is whether or not there is a demonstrated, sustained annual growth to be able to effectively evaluate their



activity. They were experiencing problems with donors only being renal donors and not multi-organ donors. Much of the publicity they received in fact quoted the numbers of increased organs as opposed to the number of increased donors. This was a bit misleading in the press.

Lastly, each province defines "donor" differently. In Ontario, a donor is a patient who has been declared brain-dead, where consent has been obtained and organs were retrieved and transplanted. While not every province will define their donors quite so clearly, we do know that in many of the provinces, their donor numbers are based on patients who are declared brain-dead and where consent is obtained, but not necessarily where organs were retrieved and transplanted.

We also have to bear in mind some of the national initiatives to increase organ donation. The Canadian Coalition on Organ Donor Awareness has a major project under way. Taking the lead from programs such as those for teaching about recycling, they are developing a cross-curricular school program on organ donation to be piloted in 1994 and launched in all provinces in 1995. The curriculum adviser who is developing this, by the way, is located in Guelph.

This will assist MORE in attempts to reach the varied multicultural groups that are untouched by programs in French or English. It is hoped that by students taking material into the home, they will be able to translate the need for organ donation into both the language and the culture of the family so that discussions can take place.

Briefly in summary, I'd like to say that the MORE program is acutely aware of the impact of the ever-growing waiting list for renal transplant patients. Several initiatives are being implemented and they will be evaluated as we address the problem. Sharing for highly sensitized patients will continue. Once on the waiting list, MORE will ensure that patients receive organs in a fair and equitable manner.

MORE will continue initiatives to enhance professional and public education programs based on the needs of the community, and these will be monitored for efficacy and modified when and as needed. Thank you.

**Mrs Sullivan:** Thank you, Ms Rosell. I'm very interested in the presentation you've made today. I think we're all delighted that you were able to be with us.

As you know, I have contacted your organization with respect to the concept of presumed consent and was interested to know of the study that you are doing. We'll be looking forward to seeing that.

I'm interested as well in the issues that you've identified with respect to professional reluctance to approach families and friends of the potential deceased with respect to possible organ donation. I wonder if you'd comment on how the issues are dealt with, say, in medical school: on whether in fact those discussions are being left too late in the process—at the time of death rather than routinely during visits to the family practitioner or whatever; on whether in fact your view might be that the physicians, particularly family physicians, may not be comfortable with the actual determination of brain death; and on whether the facilities in community hospitals are

at a sophisticated enough level that one would expect that donations could be as readily made, say, at the Oakville hospital as they would be at the Toronto Hospital.

1740

**Ms Rosell:** I'll start with your first question.

**Mrs Sullivan:** I always get them all in so that he doesn't cut me off.

**Ms Rosell:** In terms of what is occurring in medical schools right now, it really varies by medical school. Generally, all of the transplant physicians and surgeons are also involved with teaching at medical school, and what they ensure is that when the students are given patient scenarios they always build a scenario around a transplant, potential transplant or potential donor.

At one point I did ask whether or not this was worth pursuing to get as a definitive part of the curriculum, and one of the things that was shared with me was that there are so many issues right now to be put in the curriculum that we probably were achieving more with having it done in this manner than to fight a battle to try and get 15 minutes specifically for organ donation or transplantation.

In terms of approaching the families, this is a major concern and issue and why we focus everything, as much as we can, within the hospital. There are many people who are still not comfortable around the whole concept of death, and there are some physicians who, when they were an intern or a medical student or a resident, if they saw a bad situation occur with a donation or with a transplant recipient who didn't fare well, that's what stays with them, not the successes. The reluctance is, "Oh, why put the family through that?"

Certainly one of our major thrusts this year with organ donor awareness is to the health professionals: "Don't make that decision on behalf of the patient or on behalf of the patient's family. It's their right to make that decision." But for them to have that right, you have to present the scenario to them. We've certainly been trying to do that.

We also, where possible, encourage hospitals to have someone other than the physician make the initial approach or initiate the discussion with the family. Sunnybrook hospital has a very effective program where the chaplaincy is to be called with all deaths so that the chaplain is responsible to ensure that organ or tissue donation has been considered.

We know that in several hospitals they utilize the social workers, and sometimes in the ICUs it's the ICU nurse who has been close to that family, taking care of the patient, who initiates a discussion about it. What we have tried to do, and what we will do as we decentralize our teaching staff, is to encourage a hospital to come up with the best group to do the approaching of the family for that hospital, and not say it's a person province-wide.

On the comfort level about brain death, neurosurgeons and neurologists generally are the ones who diagnose brain death, but in fact any physician can diagnose brain death. But unless a physician is dealing with this all the time, they're very reluctant to make that commitment. We do try and provide education on an ongoing basis about



how to diagnose brain death and, for the nurses, how to support the doctor in diagnosing brain death.

Actually, after having our educational people out there for five years now, we're just at the point where the physicians are coming to us. Before it was always us having to beg them to let us in, and now they're coming to us with, "Let's hear what you had to say again, because maybe now we're prepared to really start hearing that." But there's no question that, outside of the neurology or neurosurgery field, there is a reluctance to embark on diagnosing brain death.

To the credit of the transplant hospitals, I will say that very often what they will do where there is not a neurologist or neurosurgeon on staff is they will say, "If you think this person is going to be brain-dead or is brain-dead, transfer them in as a transfer of a patient you want assessed and we'll do the diagnosis or we'll do the assessment of brain death here." That has made a tremendous impact on donor rates.

In eastern Ontario, in the Ottawa region, they have in fact been able to achieve significant increases in organ donation, because their RCC has really been out there and working for five years and been accepted. It's a fairly small, containable, workable area for one person, and the hospitals, particularly the Civic, have initiated a process where you've got a donor coordinator who actually makes the request of the family. Those initiatives have been very positive.

In terms of the facilities in the community hospitals for being able to maintain a donor who has been diagnosed as brain-dead, again the transplant centres have been pretty open with the community hospital, saying, "If you can't do this, you can transfer them in." Toronto General does keep a bed in its ICU for donors. But I think we also have to say that oftentimes reluctance by the community hospital is an issue of they just haven't done it before so they're scared to make that first leap of faith.

About two years ago Ross Memorial Hospital in Lindsay undertook to do an organ donation and have the retrieval there in the hospital. In talking with the unit manager, because he knew people were going to question the expense etc, he did a cost analysis within the community hospital. By rearranging some surgery and doing some shuffling, basically the cost to the hospital was \$1,000 to do the organ donation. What they were saying is if that you're looking at doing one or two or three of these a year, it's not an insurmountable cost for the hospital to absorb.

Is that all? Have I answered your questions?

**Mrs Sullivan:** I don't think the Chair is going to let me get away with anything more.

**The Vice-Chair:** Thank you for the information.

**Mr O'Connor:** It's interesting you mentioned Ross Memorial. That's where my young lad was born seven years ago.

In reading some of the information that you put together, there was a program on the weekend that showed to me the concern over the black market down in Latin America over organ retrieval. It's amazing. We may talk about it up here, for some of us who have had the

opportunity to discuss with some people who are better informed than perhaps a lot of the misinformation that is circulating out there. We really have a lot of barriers that we need to overcome, not only here but abroad.

I think the only way we're going to overcome some of the concerns is through education. Having a week set aside to talk about it I don't think is even enough. I think the media need to be involved in this process a little bit more and held accountable for not being able to promote something that actually will be cost-saving in the end and offer a much better and healthier lifestyle people can have through an organ transplant, as opposed to continuing, in this case, dialysis, though the organ transplant isn't for everybody, because it doesn't quite work out that way.

**Ms Rosell:** Just to comment on the black market issues, the program you saw on the weekend, I don't know if that was the one that was a combined BBC and CBC program. There was one on several months ago about that. There was something on one of the scandal sheets recently too, where someone's child, when they got ready to bury him, all the organs had been taken. The family assumed that they had been used for transplant. You can't take solid organs out without the heart beating. There's that window of opportunity when they're brain-dead, the heart's going to stop and you get them out at that time.

Oftentimes those organs may be taken for other things, like cosmetic purposes, to do experiments in some of the research labs etc. It's unfortunate very often now that because transplant is such a high-profile issue, there's an assumption by many less-educated people that this is where they're going. You're right that the education never ceases.

I chair the committee of the Canadian coalition's program on schools. I have been vehement in getting a school program under way, because we started to look at doing programs for various ethnic communities. We got the list of the ethnic communities within Ontario, particularly within Toronto. There's this huge list. In the States, their idea of doing an ethnic program is for African-Americans. We looked at African-Canadians, but you have African-Canadians from Africa who require one program, African-Canadians from the islands who require a different program and African-Canadians who just happen to be black people born in Canada for many generations but who require a different program altogether.

We knew there were no resources available to address all those different ethnic issues, which is why I have been committed to the school program, because I think that's the only way we can begin to get the message into so many culturally diverse homes, where the discussion takes place. If I go into a Chinese home and try to talk to them about organ donation, there are language barriers; I don't know and understand all the cultural issues. Yet the children do and they can initiate those discussions, and it's in a much warmer environment than someone from the outside going in and trying to do that. That's what we're trying to achieve.

The other thing is, our general promotion is that Organ Donor Awareness Week is every week. Even though there's a greater participation by many other agencies for Organ Donor Awareness Week, we do other promotional events. Last year at Christmas in fact, we put together a very specifically targeted Christmas public service announcement. We just sort of tried this holiday-theme PSA and we were quite dumfounded at the response we got, so this year we are targeting for the major awareness programs: April for Organ Donor Awareness Week, which is the classic one; Thanksgiving will be targeted as the time when the recipients give thanks to those donor families very specifically for what they've been able to achieve; and the Christmas, again looking at the gifts at Christmas and that these people have had the gift of life. Those are some of the initiatives we have.

For us it's often an issue of not just doing programs, but we want to manage the programs and manage them well. We feel like what we're trying to do now is those programs which we feel we can manage and be able to be effective at the same time.

**The Vice-Chair:** Thank you very much for the presentation you've made. We sincerely hope that your awareness programs result in increased donations.

ARTHUR SHIMIZU

**The Vice-Chair:** The last presenter is Dr Arthur Shimizu. Welcome to the committee.

**Dr Arthur Shimizu:** Thank you very much. I'm a nephrologist running a dialysis program in the Niagara Peninsula, which is a non-university centre, and I'm just going to give you my perspective.

I would like to thank the committee for inviting me to say a few words about the growing crisis in dialysis service in Ontario. I'm going to read this because I've got it down to exactly 15 minutes. On this issue I would like to make three simple points. I'm going to expand on them, however.

Firstly, a major concern of mine is that with the mounting fiscal constraints imposed on the hospitals with expensive dialysis programs, dialysis may not become available to all who may need it. Two constituents I am particularly concerned about are the elderly and the aboriginal peoples of the north.

Secondly, I wish to make a few comments, briefly, on some possible strategies which could be employed to reduce the heavy financial burden of dialysis programs in Ontario.

Lastly, I would like to raise the problem of renal failure among the native populations of the north.

With regard to the first point, I would like to quote Dr Dimitrios Oreopoulos of Toronto Western Hospital, who states in an article to be published soon:

"The worldwide increase in dialysis of the elderly suggests that in the early years when access was limited, these people were excluded from dialysis. With more liberal acceptance criteria, most of these patients are now accepted. However, with restrictions in health care spending the first group to be considered as expendable are the elderly, as Kilner demonstrated in his survey of the directors of 452 dialysis units in the United States.

Financial restrictions have a powerful impact upon patient selection for dialysis. While today only 10% of dialysis directors would reject patients on the basis of age, 85% indicated that they would do so under conditions of significant scarcity. A recent survey of directors of Canadian kidney units showed that 10% of them would apply age-limited criteria today." He goes on to say, "Dialysis is withheld either on the initiative of the family doctor or internist...or by the nephrologist who is responding to the host institution's financial restrictions."

Dr Carl Kjellstrand, in an editorial in the current Canadian Medical Association Journal, April 1, 1994, entitled "Hemodialysis in Canada: A First-Class Medical Crisis," makes the observation that the increasing numbers of patients requiring dialysis are elderly and the situation may be worse than that indicated by Dr Oreopoulos.

He states, and I quote, "We are not even close to providing the necessary care for all elderly patients who need dialysis." He says this because the rate of growth of the people between 65 and 74 is still steep. It hasn't plateaued. If you see a plateauing of that entrance of new patients on to a dialysis program, then you have adequate treatment for that group.

This discrimination against the elderly occurs despite the fact that I believe section 15 of the Canadian Charter of Rights and Freedoms forbids such discrimination on the basis of age.

I believe that the government and the Canadian society must provide for the elderly the same quality of care that younger members receive. The practical implication of this, of course, is that governments must augment the dialysis facilities where the need emerges. This means in the first instance, I believe, that Toronto, which is the area most in need, should have additional dialysis stations.

I believe that the detection of renal failure may be much less among the natives of the north since renal failure could be said to be a silent disease, a silent killer. History and physical examination do not lead to the diagnosis of kidney failure. One must do blood tests for urea and creatinine to make the diagnosis. If one does not seek a physician, then kidney failure is not detected, and a lot of our native people do not seek physicians.

We know from the kidney registry figures in the United States that the native Americans have the highest rate of all of the various ethnic groups, including blacks, of new patients entering into the dialysis programs in the United States: 324 patients per million population as opposed to Caucasian American rates of 125 new patients per million population.

In our Canadian figure it's about 105, 106 per million population for Ontario. Dr Dyck of the University of Saskatchewan has made the same observation among the natives in Saskatchewan. I believe that efforts should be directed to determine if native Canadians are receiving the same access to dialysis treatment as other Canadians.

My second point is to discuss briefly with you possible strategies to reduce the cost of dialysis.

The first one is reuse of dialysers. The single most



expensive item in the dialysis treatment is the dialyser, the filtering apparatus, costing between \$25 to \$40 per dialysis. It is used once and discarded, very environmentally unfriendly as well. It can be reprocessed:

It can be reprocessed five to 10 or more times, and in the United States they may even do it up to 25 or 30 times, and thus lead to substantial savings.

When automated reprocessing equipment is used, it has been proven to be safe and its efficacy as a dialyser is maintained.

Currently only 10 units out of the 80 units in Canada reuse dialysers and only two units reuse dialysers in Ontario—and mine isn't one of them—while in the United States 85% of all dialysis facilities reuse dialysers.

**1800**

E. Baris and M. McGregor, in the January 15, 1993, issue of the Canadian Medical Association Journal, carried out a thorough review of the literature on reuse of haemodialysers and concluded that only five uses might save up to \$3,629 per patient per year. There are currently 5,050 haemodialysis patients in Canada, 40% of whom are in Ontario, by the way. If 80% of these patients' dialysers were reused, there would be a saving of \$14,650,000 per year per patient. If you take into account the escalating numbers of patients coming on to dialysis, you can just do the mathematics and figure that out.

The second item which may help to reduce costs has something to do with manpower and is the employment of nurse practitioners in dialysis. This is akin to the use of midwives in obstetrics. Since the dialysis population is growing at the rate of 5% to 10% over the previous year, more nephrologists will be necessary in the future. Some of this need, I believe, can be accommodated by training nurse practitioners in dialysis; not all, of course, but some.

In 1974, when I was still in Hamilton at McMaster, I initiated a nurse practitioner program and since that time the original two nurses have increased to about four. I believe Hamilton has the highest patient-nephrologist ratio of any university because they have 300 patients and they have only seven staff people. That's a lot of patients one physician looks after and that's partly because it's nurse practitioners.

They can function as well as a resident in nephrology—that is a doctor in training for kidney diseases—solving some 85% to 90% of all problems. Nurse practitioners must be introduced initially in large university centres since I believe at least three nephrologists are necessary prior to the institution of a nurse practitioner program, which means that a centre must have at least 150 patients or so before one employs a nurse practitioner and they should work under the supervision of nephrologists.

The third strategy that one could employ to reduce the cost of dialysis is the concept of bulk buying. Since Ontario has 40% of the total dialysis population in Canada, in some way this should be turned into cost advantage for Ontario. I believe British Columbia does something like this to a certain extent.

Capital equipment, disposable items such as dialysers,

tubing, dialysate solutions, peritoneal dialysis equipment, monitoring equipment, technical contracts for equipment maintenance could be bought by a central agent on behalf of all dialysis units in Ontario. Standardization of equipment and limitation to certain numbers of items should be jointly worked out by a body made up of providers of dialysis: administrators, nurses, technicians, physicians and probably patient representatives, such as the representative from the Kidney Foundation of Canada.

The last point I wish to make concerns the plight of the native people in the north and kidney failure. Native people have a high incidence of kidney failure, as I have previously pointed out.

Much of this is due to diabetic kidney disease, the type referred to as non-insulin-dependent diabetes. This type of diabetes occurs usually in individuals over 40 years of age but, among the native population for some reason there is a large proportion of these patients even among teenagers and young adults and, I've heard, patients 10 years of age.

Much can be done to see if one can prevent kidney failure and blood vessel complications of diabetes through diabetic education programs among native peoples in the north. This may cost money, but if one prevents some of these patients from going on to kidney failure, money will be saved. In fact one patient not going on to dialysis may save you \$60,000, right?

Once native patients go on to kidney failure, they must leave their reservations with their families and move to urban areas of Thunder Bay, Winnipeg, Saskatoon and other places, of course, with all the social disruption and social illnesses that are attendant upon much of our native population.

Perhaps it would be better if we established a medical clinic in the reservation and sent nurses into the community to perform thrice-weekly dialysis or train a person in the reservation and supervise them over the phone and frequent visits, perhaps once a week or once in two weeks, or a combination, rather than bringing them in to the inner city, because of the social problems. I know there are social problems in the reservation, but I think there could be more in the city for the natives.

This possibility does lead to increased costs but it may also avoid some of the costs of social disruptions when families must be brought into urban centres where they can require public assistance which can lead to strain on the public purse. Thank you.

**Mrs Sullivan:** I'm interested in the recommendation that you make with respect to reprocessing or reusing the dialysers. I've been at St Joseph's Hospital in London where in fact there has been the introduction of some of the reprocessed units and I understand they're working very successfully. I just can't remember offhand how long that's been in place.

Can you advise, why, by example, there are only two units in Ontario that are using the reprocessed dialysers? Is there a capital cost factor involved in the first place that would make people reluctant to do so?

**Dr Shimizu:** But including the capital cost, these figures—



**Mrs Sullivan:** We're talking about a life-cycle. What would the net saving be?

**Dr Shimizu:** When they quote these figures, they incorporate that capital cost.

**Mrs Sullivan:** So the figure you've quoted of \$3,000 a year is the net annual saving, including the capital cost. What you're saying, then, is that the initial capital cost of the reuse is where the hospitals have difficulty in bringing in the equipment, or is that the only reason—

**Dr Shimizu:** No, but you can purchase it over time.

**Mrs Sullivan:** Why aren't more hospitals doing it?

**Dr Shimizu:** Because of some of the adverse publicity that attended manual reuse and reprocessing dialysers. If you use an automated reuse procedure, it's safe. I got a \$150,000 grant 10 years ago from the Ontario government to study it. We found that whether you use the new dialysers or reused dialysers, there were no more complications, one way or the other. We were using formaldehyde then, which is far more harmful, but we don't now.

1810

**Mr Jim Wilson:** Thank you for your presentation. You've obviously put a lot of thought into how cost savings could be achieved and I thank you for those suggestions.

But I want to just very briefly go back to rationing by age. I've read the reports that you refer to and that others have referred to in this committee. I guess as politicians we're interested to know what the extent of rationing is. I'm gathering that's pretty hard to figure out in this province, because a lot of it is anecdotal.

**Dr Shimizu:** That's true. Some people just don't refer because they know the climate. For instance, our hospital did a review of our dialysis program, because the medical staff, that is, the non-kidney physicians in the hospital, wanted a review, because they thought we were accepting too many diabetics, too many elderly and so forth, who will not be useful to society. I've done reviews in Kitchener-Waterloo on the same issue.

We are pressured. When the administrators tell you, "When we put money into your program, we have to take it out of the OR time," that kind of thing—don't forget they're working on a global budget and you're competing for those scarce dollars. People are fighting each other, that is, the physicians who are not kidney doctors don't like you if you admit an 85-year-old woman who they feel is not that healthy.

**Mr Jim Wilson:** Your answer's very useful, because of course for the last 20 years, politicians have run around saying, "We don't have user fees; we don't have rationing; we don't have two-tiered medicine." I call them the three mythologies of health care. It's refreshing to have physicians talk about what you do on a daily basis, which is, to some degree you have to ration services. That's part of getting your licence as a physician.

**Dr Shimizu:** In the United States there are 661 patients per million population. Canada has about 520 per million population and Japan has 877 patients. What I'm

trying to say is that in the United States, with the free market working that it is, as Dr Kjellstrand says, the facilities chase for the kidney patients. They're looking for patients, and if they're looking for patients, obviously they're going to attract them, and you're going to get the right number that actually should be on it. In a system where everybody's trying to constrain, constrain, you subconsciously will maybe reject—read ration—subconsciously. It's got to be that. And we as responsible doctors try to do the best for our hospital.

**Ms Jenny Carter (Peterborough):** Thank you very much for a very constructive presentation. Particularly your money-saving ideas seem very practical. But I wanted to follow up the question of aboriginal people. It's become very clear that they do have a higher-than-average incidence of diabetes, and you talk about education to help reduce that.

**Dr Shimizu:** Well, a program to perhaps, by spending money on education—because, you know, there are some studies in the insulin-dependent diabetic now. Not the non-insulin. The British are doing a study on non-insulin-dependent diabetics and the results are not yet out, I don't think. That may suggest strategies that one can employ in the management of patients with diabetes that prevent development of end-stage renal failure.

**Ms Carter:** That's what I'm wondering.

**Dr Shimizu:** That's what I mean by education.

**Ms Carter:** I suspect that in their original way of life, they would not have had this incidence of diabetes—

**Dr Shimizu:** No, they wouldn't.

**Ms Carter:** —and that it's a maladjustment to the kind of lifestyles they're now living. I'm just wondering how much research is being done into how their lifestyles would need to be readjusted, as it were, to prevent that diabetes from happening in the first place.

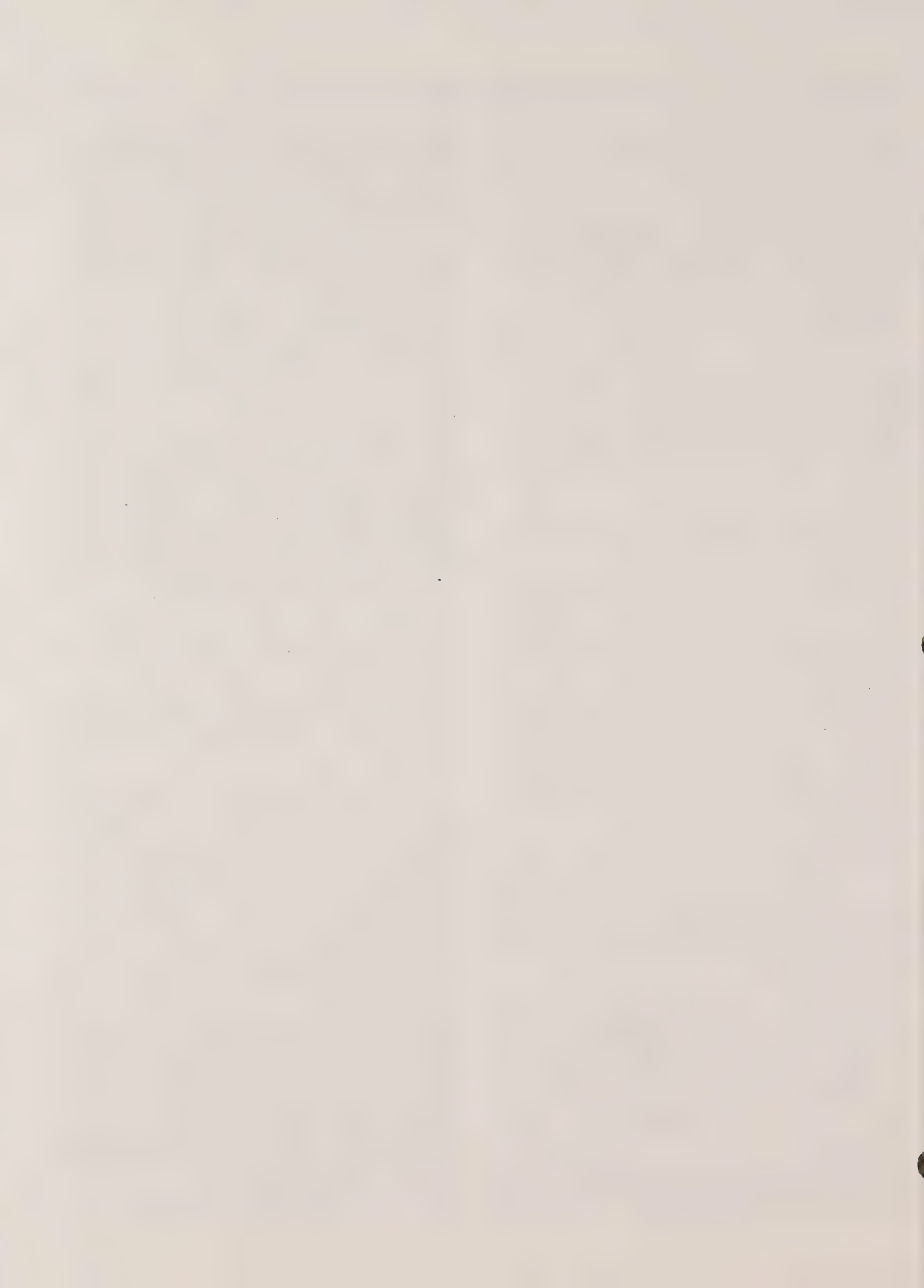
**Dr Shimizu:** This is my personal interpretation and it may be biased. My feeling is that because the natives have been ignored in many areas of our life, I think they have been ignored in this area as well. Attention has not been paid. People discriminate, if I may say so.

**Ms Carter:** I think they were adjusted to a kind of lifestyle where they maybe ate large meals less frequently and their metabolism slowed down during the winter and they wouldn't have had a large intake of sugar, as they probably do now to a greater extent. Is there any kind of research being done into exactly what is wrong and how they could compensate for that?

**Dr Shimizu:** There are some thoughts, but I'm not an expert in the diabetic area, so I cannot very well comment. I just want to point out that I think a considerable number of things can be done in studying these people and more funds should be spent in trying to get the natives to follow diabetic diets and diabetic management protocols. I think education is important.

**The Vice-Chair:** Thank you, Dr Shimizu, for your presentation. The committee will adjourn until tomorrow at 3:30.

The committee adjourned at 1816.







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Murdoch, Bill (Grey-Owen Sound PC) for Mrs Cunningham  
Sullivan, Barbara (Halton Centre L) for Mr McGuinty  
Wessinger, Paul (Simcoe Centre ND) for Mr Owens

### **Also taking part / Autres participants et participantes:**

Wessinger, Paul, parliamentary assistant to Minister of Health

**Clerk / Greffier:** Arnott, Doug

**Staff / Personnel:** Gardner, Dr Bob, assistant director, Legislative Research Service

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of Ontario**

Third Session, 35th Parliament

**Assemblée législative  
de l'Ontario**

Troisième session, 35<sup>e</sup> législature

**Official Report  
of Debates  
(Hansard)**

Tuesday 19 April 1994

**Journal  
des débats  
(Hansard)**

Mardi 19 avril 1994

**Standing committee on  
social development**



**Comité permanent des  
affaires sociales**

Dialysis treatment services

Services de traitement par dialyse

Chair: Charles Beer  
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## LEGISLATIVE ASSEMBLY OF ONTARIO

## ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON  
SOCIAL DEVELOPMENTCOMITÉ PERMANENT DES  
AFFAIRES SOCIALES

Tuesday 19 April 1994

Mardi 19 avril 1994

The committee met at 1544 in room 151.

## DIALYSIS TREATMENT SERVICES

Consideration of a matter designated pursuant to standing order 125 relating to dialysis treatment services.

**The Vice-Chair (Mr Ron Eddy):** Good afternoon, ladies and gentlemen. Welcome to the standing committee on social development, presently holding hearings on standing order 125, the designated matter being dialysis treatment services.

## CALVIN STILLER

**The Vice-Chair:** By negotiation, the first presenter will be Dr Calvin Stiller, chief, multiple organ transplant service, University Hospital, London.

**Dr Calvin Stiller:** I'm Cal Stiller and I run the transplant program at University Hospital in London.

The problem before the committee has to do with the support of patients in chronic renal failure. All of my historical interest is as a nephrologist. My current responsibility, and for some time now, has been that of transplantation.

I co-chaired the task force of the ministry in 1984 which put forward what we obviously unrealistically said was a blueprint for success in terms of organ donation in the 1990s, and I'm here to tell you that we are a dismal failure and it's time that we faced it.

There has historically been a gap between supply and demand with respect to kidneys, and this continues. The important thing for us to recognize today is that none of this should be a surprise to us. We saw it coming; it's predictable; it's predictable in the future.

Obviously, the way to reduce this enormous burden and increase the life and vitality and employability of individuals with kidney failure is to prevent kidney disease, and we don't have any answers for that. There are a couple of things on the horizon which we should be aware of. One third, or 31%, of all patients coming on to dialysis are there by way of the disease diabetes.

A recent international study, in which there were Canadian centres participating, has shown a reduction by 50% of the incidence of the development of kidney disease in those individuals who have diabetes by way of administering insulin on a continuous basis, as opposed to the once- or twice-a-day injection of insulin. That's not going to immediately alleviate the problem, but it's that kind of research which is absolutely critical for us to solve this problem in the long term.

The incidence of chronic rejection in our transplant patients, our half-life of a kidney that we transplant, is

only about nine years. Chronic rejection takes 2% to 3% per year. Important new research endeavours that are reducing the incidence of chronic rejection are very important for us to support.

I would just put on the record something that many of you have heard from me on repeated occasions; that is, the dismal record of Canada, and Ontario's no exception, in the support of research. We are virtually putting nothing into the area of health research.

I would point out to you the recent tack-on that Harkin put on the Clinton bill in the US, which is a set-aside fund of 1.5% of all transactions, both those purchasing and those supplying, for the purposes of solving their health care problems with respect to research. Canada should be doing something very much the same.

The only other way for us to deal with this as things currently stand, other than transplantation, is rationing. I don't believe it's acceptable to our population to ration. We have seen this coming, and immediately we have to provide the dialysis stations for these patients. There's no easy method. If you apply rationing, it would have to discriminate on the basis of age and disease, and in my opinion our society would not accept that. In any event, I believe that there are ways we can, in converting our health care system to a rational, evidence-based system, begin to reallocate the kinds of moneys currently spent to have better outcomes.

The optimal treatment for kidney failure is a transplant. Everybody agrees on that. Success rates are in the region of 80%. There's an annual loss of about 2.5% per year after that. The cost of a transplantation is about the same as one year of dialysis.

## 1550

The organ donation rates in Ontario are about 15 per million per year, giving rise to 25 per million per year. Now, the rate varies in various regions. In southwestern Ontario we have about a 50% greater rate, 23 per million per year. But there are areas in the States—an area in California, an area in Florida—that have approached this very aggressively with specific programs and have achieved 35 to 45 per million population. In this week's issue of the Canadian Medical Association Journal, I put forward several of those issues that I think should be considered.

I'm just going to track for you what happens to patients when they go into kidney failure and tell you the kind of effect we could have. About 100 per million population per annum go into kidney failure, and we know those individuals, largely, who are going to.

There's an average of about four years of tracking those patients. They require dialysis, and in the time around dialysis—investigating them, setting them up, training them and into dialysis—we have a front-end cost, and then about \$45,000 per year thereafter.

Twenty-five per million population will receive a cadaver transplant, and that cost is about \$40,000 for the transplant and thereafter, all costs being considered, is \$7,500. I would point out that the outcome is 80% or better, and the vast majority of those work and, I'd point out, pay taxes. Living donors account for about six per million per year. So overall, of these 100, about 31 will end up with a transplant and 69 will end up on dialysis.

What can we do about this? How can we increase this rate? I'm going to also concentrate on this rate.

We have about 25 per million population per year in terms of kidneys. As I say, in southwestern Ontario we have about a 50% better rate than that, and there are areas in the States that have a donor rate of 35 to 45. That is 70%. So it's conceivable that this could be taken up to 70% if we had an effective cadaveric organ donor program. Why don't we?

I'd like to put to you what the strategic plan for managing chronic renal failure and organ donation and transplantation in Ontario is, a carefully thought-out plan. It has historical precedence. It's faith, hope and charity.

When an individual dies in a hospital in Ontario, and that donor is missed or the relatives aren't approached, what's the significance of that in a hospital? If I were to come in from the outside and look at the hospital records or hospital policies, in orders of priority, these would be the things that would be important: an individual who dies around the time of an operation, an individual who falls out of bed, a needle prick for one of the staff, and a skin rash for a drug reaction. You will find no record of a missed donor. It is of no importance with respect to tracking or auditing in our hospitals in Ontario.

The primary problem with transplantation in this province and in this country is lack of leadership. It's not lack of political leadership; it's lack of leadership from any sector: from the College of Physicians and Surgeons, from the Ontario Medical Association, from the Ministry of Health, from the hospitals, from the physicians. There is no champion for this and there's nobody who says, "We have a resource that's being wasted and we must track it."

Every kidney we lose costs this province \$45,000 per year, and for 10 years on dialysis that's half a million dollars. More importantly, it fails to release a patient from the prison of dialysis.

I'm going to talk about another piece of this, and please don't become defensive. I see some of the physical responses being defensive. Nobody needs to be defensive here. We just all need to feel very guilty. Cal Stiller, who has been at the forefront of transplantation for 25 years, is here to say, "Mea culpa; I have failed." It's time we recognized that we have failed. Face up to our problem. Stop living in a dream world.

There's another area, and that is living donation. I want to talk about that because it's something we don't

talk about and I think there's a unique opportunity for Ontario to really take a lead. I also think it's going to have a spillover effect with respect to cadaveric donation.

When an individual develops kidney failure—let's take AD, for example, this being one of the siblings—they have a potential for donation within that family. AC—this represents tissue typing—could get an identical transplant from one of the siblings who is tissue-type identical, or half identical, each getting half of one chromosome from the parent. So there's a one-in-five chance, really, at any time that you'll have a sibling who's identical.

You have virtually a 100% chance that you're going to be able to give to your parent, or your parent to you, if you are compatible by blood group, and that's a critical fact.

At the present time, we have six per million population per year who give a living related donor organ. I'm going to put forward that with some innovation, some real sociomedical innovation and leadership, we can take that to 30. In other words, we can deal with one in three of every individual who comes on to dialysis.

If we don't change, if we stay exactly the same way we are, 25 plus 6, 31 per million population, are the number of kidneys that we can transplant. There are 1,000 new patients who come into kidney failure every year in Ontario. A thousand times \$45,000, read it that way: \$45 million. Three hundred—310 to be exact—are going to get a transplant.

If we do nothing, over a period of the next four years, that difference will build every year. So over four years we have accumulated about 350 new patients times \$45,000 each year. That's the effect if we don't change.

#### 1600

There's a concept I'm going to put forward to you which surfaced from an individual called Felix Rapaport in New York some years ago and has never been explored. I think maybe this is the time to explore it.

Let's assume for the moment that Dr Wilson has a sibling that he wants to give a kidney to and cannot because either there's a positive cross-match or you have an incompatibility with blood group. Let's assume for the moment that I have the same situation: I am prepared to give to one of my siblings but cannot because of incompatibility with blood group or antibodies. I want to give, Jim Wilson wants to give, and we have the opportunity to do something that I call vicarious living-related. In fact, if I'm prepared to give into a donor pool and Jim Wilson is prepared to give into a donor pool, my brother gets transplanted and Jim's brother gets transplanted.

There will be naysayers on that. It is not a barter system. It's taking responsibility for the health and care of our families, being able to express the altruism and love and charity and grasping the faith and hope that fit the other part of that, and allowing us to free those individuals from dialysis, if we did two things: if we put in place a system where leadership is given and we made organ retrieval, the retrieval of living organs from cadaveric donors, a real issue.

If there was a disease from which patients were dying and we had the cure and that serum that cured that



patient was available and there was no financial, ethical or logistical reason why we didn't get that serum to the patient to cure that, the College of Physicians and Surgeons, the federal and provincial governments and the OMA would be up in arms, the media would be on it, and we'd have that problem solved.

We have a situation today in which 88% of the population want to donate the organs of their loved ones and in fact two out of every three of those potentials are lost because we don't consider it important enough. If a system as disjointed as the American system can put forward a plan in a region in which they can achieve these kinds of levels—this isn't pie in the sky; this is what they're achieving—then in a system like Ontario we should be able to do that.

If you added to that an aggressive living-related program in which patients were truly informed—I can tell you the patient families in our current system are not informed of either their right to or the relative risks involved. The barriers are not removed. Patients are on dialysis and five or six years later their relatives have found they could have donated. This is not a responsible health care system that allows that to happen.

If those two could be achieved, we could almost reach—and this is not accounting for the mortality that occurs in this system, because there's a 13% annual death rate in those patients who come into that dialysis program of 1,000 a year—we in fact could achieve a steady state. I would point out to you that the cost savings involved in that are enormous, but we do not have a system.

The problems, just to finish, are that we have a demand or a need exceeding supply. Chronic renal failure is increasing. Patient numbers exceed the bed numbers. That's the crisis you're dealing with in Toronto, and I'm telling you that it's about to surface in every other community in this province.

The number of new chronic renal failure patients has always exceeded the number of available kidneys for transplantation. Patients in need exceed the number of donor organs. There's no real program for maximizing the number of donors and no effort or capacity to stimulate research into new solutions.

I can tell you that the system is squeezed. There's no rational financing that allows incentives for creativity, and platitudes and hope exceed reality and action. The care of renal failure and transplantation is balkanized with multiple disincentives and barriers to a seamless progression through the stages of optimal treatment. The amount of work and lack of coordination stifle innovation.

I believe the fundamental problem lies in the multi-sourcing and method of financing of health care. Solutions to the causes of renal failure, including diabetes, immune diseases of the kidney and chronic rejection—the research needs exceed that amount of support.

I'm going to put forward what I think the solution is. The solution is, face the problem. Stop dreaming that our current system of cadaveric and living donation is going to solve the problem; it's not. There are 3,000 patients on dialysis in Ontario. We transplant 300 a year. Transplantation is rapidly becoming an irrelevant side issue when

in fact we know it's the optimal treatment.

The short-term solution is to provide adequate dialysis stations. You cannot say to the patients who are currently facing dialysis, "We're not going to give you dialysis," because frankly, we've known about this problem for the last five years. We had the opportunity to provide for it.

Activate a comprehensive living donor promotion program, starting with the traditional living-related and giving everybody the opportunity, and then introduce a pool exchange and do that on the basis of a well-designed experiment.

Give leadership. Roll out an organ donation program enlisting hospitals, physicians and the public. The mid-term solution is creating a task force. Give them six months to come back with a workable process and organization. I believe that ultimately the only way to look after this is a health maintenance organization equivalent that deals with those individuals who are coming into chronic renal failure. We know who they are and we know what they need.

We cannot allow balkanization of the system which impedes patients from getting to what is the optimum treatment, and that's transplantation. Thank you.

**Mr Jim Wilson (Simcoe West):** Thank you very much, Dr Stiller. It was an excellent presentation. A two-part question: First, and I think we may have been told this, what's your advice on how many people who have renal failure would be candidates for a transplant each year, and secondly, what percentage?

Your suggestion about a vicarious living-related donor program is very interesting indeed. It somewhat reminds me of the current bone marrow registry.

**Dr Stiller:** Precisely.

**Mr Jim Wilson:** That's what the model is, is it?

**Dr Stiller:** Yes.

**Mr Jim Wilson:** I just wonder, do people really want to give up kidneys? Bone marrow is one thing; you're extracting some marrow out of the body. But to actually give away an organ seems to me to be something we'd have to do a lot of public education on.

**Dr Stiller:** I'm amazed at the charity and goodwill of people when presented with a problem and the reality. When you say, "My brother's going to have to be on dialysis—an average of two and a half years; it could be 10—"and I have the opportunity to get that individual before he ever goes to dialysis"—which means the likelihood of that individual not going into disability and losing his job, but maintaining his role in the home and being able to work—"I have the opportunity to do that and I know what the statistics are with respect to morbidity and mortality"—the majority of individuals, when presented with that—and we have a very clear distinction between the recipient advocate and the donor advocate. They're seen separately. They're counselled. They're seen by a psychiatrist. They're looked after very carefully. The vast majority of them say, "Let me do my part."

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**Mr Jim Wilson:** The first part was, how many people would be candidates?



**Dr Stiller:** You're going to hear different figures. The way to ask the question is, if you were throwing away 1,000 kidneys a year, how many of the patients would be suitable for transplantation? The answer is, almost all of them, 85% of them. It's been shown in every study looked at that if you have an individual who has a medical risk factor, and it's irrespective of age, the life survival and the level of rehabilitation is better with a transplant than with dialysis. I think that's the answer.

It's because we have such despair with respect to whether a transplant is even likely that they're not even considered. As a consequence, in some programs we have as little as 12% of patients who are on dialysis actually listed on the transplant program.

**Mrs Barbara Sullivan (Halton Centre):** I'm very interested in this presentation. I think that throughout the hearings with respect to dialysis we've been hearing the underlining of a need for a comprehensive program. This is a different comprehensive program that is being presented so far. We have had some earlier discussion with respect to transplant programs in which the barriers were underlined to a certain extent. I'm wondering what you would see as the barriers to a very aggressive program such as you've suggested.

**Dr Stiller:** Of course, the barriers on the side of organ donation largely lie in the hospital. It is the failure to identify donors, care for them and approach the family, and there's a variety of reasons for doing that. But I can tell you that if you don't value something, it's not going to be done by people who are overworked. Does that limit patients who have a potential living donor? The answer is no. So why the barriers? It's difficult to know how candid to be; it's not usually thought of as a problem for Cal Stiller.

There are significant barriers. There are barriers that relate to the financing of the support of dialysis versus transplantation, physician income, the role of the tie-in between dialysis and transplantation—peripheral dialysis units and transplantation. An enormous problem exists with respect to proper education of the patients, making sure that they know their options. Frankly, what happens is that if a patient comes to dialysis, if you refer that patient on for transplantation, there's an enormous amount of work involved in terms of that living-related program of counselling. There are not enough people to do that. There's no identifiable source of funding for that.

The income to the dialysis unit is reduced. The work on the transplant unit is increased. Transplantation is undervalued, frankly, by OMA and by the ministry and the hospital sector. It's considered marginal. It is an enormous cost saving, that's what it is. It's simply a balkanized system. There's nobody who has responsibility for guiding that patient through to the most efficient, most economical outcome. I'm not pointing fingers at anyone; nobody has had responsibility for that. I just think it's time we took it on and did what the patients think we're doing.

**Mr Paul Wessinger (Simcoe Centre):** Thank you for your presentation. I think I already have the answer to my question, but I'll just confirm it in any event.

You've indicated that basically institutional problems

are the major difficulty with respect to having a more successful transplant system. At times we've had people come and say there's a problem with respect to willingness of donors or willingness of families and they've suggested such things as presumed consent and mandatory choice, but I gather your position is that you wouldn't need to look at those aspects if we could solve the institutional problems. Is that correct?

**Dr Stiller:** What I long ago learned is that what I don't know is an awful lot more than what I know. I don't know whether presumed consent works. It's been tested in different jurisdictions, but no proper control was really established to determine whether presumed consent works. It's worth an experiment and it could be done in a region. It's one of those things in our health care system that we need to move to evidence-based. For so much of what we do, we don't have any evidence that is of benefit, or detriment, for that matter.

You're talking to an optimist, you know, and I have enormous confidence in the goodwill and charity of people if they're given the opportunity. What you have to do is give them the opportunity. The physician has to take the responsibility to identify the donor and counsel the family, or somebody else has to, and move them through that system. We could introduce presumed consent in a properly laid-out, researched protocol and determine once and for all in the North American setting whether it's of benefit, and I think it may be of benefit. But until we do that, there's something else we can do. We can have physicians and hospitals take on the responsibility that they should and give everybody the opportunity to donate.

**The Vice-Chair:** Thank you very much for your presentation, Dr Stiller.

The next presentation will be by Dr William Clark.

MICHAEL SINGER

**Dr Michael Singer:** I wonder if I could go next. I've got a train to catch.

**The Vice-Chair:** Certainly. Please proceed.

**Dr William Clark:** I guess it's the rule that nice guys finish last.

**Dr Singer:** My name's Michael Singer. I'm in the division of nephrology at Queen's University in Kingston. First, I'd like to thank the committee for allowing me to participate in this discussion. Some of the issues you're addressing are certainly a microcosm of the stresses and strains in the health care system.

I would like in my presentation to go over some of the resources I think are necessary for the maintenance of a good dialysis program. I want to use six overheads for this; I think people should have a copy. Some of this information you'll have seen before, at least in the first two overheads.

What I've plotted on this graph is the prevalence of end-stage renal disease in Canada and locally in our Kingston area. The year is on the abscissa and on the ordinate is the number of patients at the end of each year receiving dialysis. You can see that over the last number of years there's been a linear increase in the number of patients receiving dialysis, and I'm sure you're aware or

have been told that this is equivalent to between about 10% and 15% per year annualized. Our experience in Kingston is very similar to the national data.

What this kind of data shows is, obviously, that we haven't reached a steady state in terms of our expanding dialysis population, that the input into the system is still exceeding the output or exit from the program. What it doesn't show is that if you look at the incidence or acceptance rate in dialysis, it itself is increasing annually, with the biggest intake occurring in the elderly population.

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If you do look at the incidence of dialysis or the acceptance rate, what I've plotted here is the United States versus Canada, this being the age-specific incidence of end-stage renal disease therapy. These are 1988 data, but I think the conclusions would be the same if one had access to more recent data. You can see that the United States incidence of end-stage renal disease therapy is greater than that of Canada at all age groups, but the discrepancy is the largest when one looks at the very elderly. In the little inset up here, I've plotted the ratio of Canada to the United States in terms of dialysis. Until the age of roughly 74, it's somewhere between 0.6 and 0.7, which means that in those age groups, we're dialysing about 60% of the number of patients in the United States. When one gets to the 75-plus age group, we're down to almost 35%.

If you assume that the demography of the two countries are not that different and the prevalence of diseases leading to ESRD are similar, clearly we're probably not even meeting the need of our existing end-stage renal disease population. These types of figures, which I know you've seen before, tell us that there's going to be a projected increase in our dialysis population, and that we may not even be meeting the existing need and we're going to need more resources. The question I really want to talk about is, what are the resources you need for a good dialysis or renal program?

With this view in mind, if one looks at the health care system and nephrologists, we've really focused a lot on the technical aspects of dialysis and on survival, really, as the main outcome. But as physicians and nephrologists, we realize that the true goal of a dialysis program, or of an end-stage renal disease program, should really be to try to maximize patient functioning and wellbeing and not merely to just preserve life.

With this view in mind, about two and a half years ago in Kingston, we began to measure patient functioning and wellbeing to see how our patients were doing. In particular, we were interested in those factors that impacted on their functioning: What were the variables that controlled their functioning, and is there something we could do about these variables?

When we looked at our data, we found there were three main variables that really related to patient functioning and wellbeing: the nutritional status of the patients, which is a very important topic in end-stage renal disease; the co-morbidities of these patients were especially important since many or most of our new patients are elderly and have coexisting cardiovascular and/or pul-

monary disease and diabetes; and also this factor I call self-care, which really relates to patient autonomy and patient control of their treatment schedules.

As we were doing these studies, we were in the process of setting up a self-care unit in the Belleville area from Kingston. The self-care unit is now operational. This is a unit where patients are dialysed in a non-hospital setting, there's minimal nursing care and there's no physician on site. We found that these patients seemed to be functioning at a better level than our in-centre patients who were maintained within the Kingston General Hospital.

So we embarked on a separate study where we took our self-care patients and we matched them with a group of patients who were not going to self-care but who were similar in age and co-morbidities. We decided to compare the functional status, the functional wellbeing of these patients. We used an instrument called the Rand SF36, a 36-item short form which measures patient wellbeing. It actually measures eight domains of health in these patients, these being the eight domains: It measures physical function, daily activities, role function, mental health, and a whole series of generic domains.

You can see from this graph that our self-care patients, who are in the closed circle, scored much better than our centre patients, who are in the open circles. This was one time point, but we've done this on a number of occasions. It was clear that our self-care patients, even though they had the same co-morbidities and ages as these other patients, did better, felt better and perceived themselves as healthier. We think this relates to patient autonomy and the ability of these patients to have more control over their treatment schedules.

When we looked at this type of data and when we looked at the literature, one can draw up a list of the kind of steps and processes you need if you're going to have a dialysis program that is not just designed to preserve life but is designed to try to improve or maximize the functional status and wellbeing of these patients.

These are the things you need to do: You need to optimize their nutritional status—very important; you need to pay attention to and treat all the co-morbidities these people have in terms of heart disease, pulmonary disease, diabetes, peripheral vascular disease; and you need a very active rehabilitation program which promotes patient control and autonomy, maintains employment where possible and also maintains the physical activity of these patients.

If you take these kinds of steps, these kinds of processes you need for a successful end-stage renal disease program, these are the types of resources you will need to have such a program. We clearly need dialysis equipment and facilities, but I would think with an emphasis on self-care modalities. We obviously need an adequate complement of nurses, physicians and technical staff, but we also need dietitians, social workers and occupational therapists if we're going to have a successful program.

I think the conclusion is that the dialysis population is expanding and does not appear to be reaching a steady state—we don't know when it'll reach a steady state in the foreseeable future—and if the goal of dialysis is



really not just to preserve life but to enhance the functioning of these patients, we need these types of resources to maintain such a program. Whether we can afford the opportunity costs for these resources I think is really a decision we have to leave with society.

**Mr Jim Wilson:** Doctor, thank you very much. Your last statement is exactly what I was thinking of all the way through, because it's come up with each of the presenters: giving the committee and government, society, the choice that we either move ahead and provide the resources for dialysis or we go out and try and get re-elected talking about rationing, is I guess how you'd put it in political terms. I think the public in general is quite educated, particularly families that know someone who requires dialysis.

I guess it's a measure of costs. You talk about the costs we need to put the resources in dialysis, or the cost to society if we don't. Do you have any further comments on that?

**Dr Singer:** Comments? I don't really have an answer as to where the costs should go. My personal view is that since health care resources are finite, obviously allocation decisions have to be made. I think the only way these can be made is in some public and explicit fashion, personally. There are models out there of processes which have been looked at to do allocation in a public and explicit fashion.

**Mr Jim Wilson:** So you'd look at something like the Oregon model?

**Dr Singer:** Yes.

**Mr Jim Wilson:** And you think the public's ready for that very frank discussion about services and treatments?

**Dr Singer:** Personally, yes, I think the public is prepared and I think they need to be involved in a public discussion of what we can afford. There is a mismatch between expectations and our resources, and I don't think it's reasonable, as physicians, that we should be making these decisions, and I don't think government, as a proxy for society, should be making them in an implicit fashion. I think this has to be an explicit process.

**Mr Jim Wilson:** Which is kind of the slope we're on with the delistings, for example.

**Dr Singer:** Yes. I think delisting is an implicit, not public, process.

**Mr Wessenger:** Thank you for your presentation. I was particularly interested in the wellbeing, depending on the type of haemodialysis. I know this only relates to haemodialysis, but I wonder if you had any comments with respect to the alternative form of dialysis, which is peritoneal. I realize you haven't done the study, but have any studies been done or do you have any observations about how patients perform under peritoneal dialysis? I understand that for many patients it's a viable option.

**Dr Singer:** We actually have looked at our peritoneal dialysis population. In Kingston about 50% of our patients are on peritoneal dialysis, some of them are on the cyclor and most of them on CAPD, continuous ambulatory peritoneal dialysis. For reasons which are not clear to me, most of our peritoneal dialysis patients, at least in terms of their wellbeing and functioning, are

more like our centre patients than like our haemodialysis self-care patients. I don't know if that's patient selection, because on average they're not older than our haemodialysis population and I don't think their co-morbidities are any more extensive than the co-morbidities of our haemodialysis patients. But their scores are comparable to our centre patients and not comparable to our self-care patients.

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**Mr Wessenger:** Would this be true even with respect to the cyclor process as well?

**Dr Singer:** Yes, although in all fairness, part of our cyclor program has really been an assisted cyclor program to try to keep patients at home who otherwise would have required institutional care.

**Mrs Sullivan:** I'm very interested in your presentation because I think it's the first time during this series of hearings that we've had a presenter speak about the psychosocial aspects of treatment, although maybe the Kidney Foundation did to a certain extent.

I'm interested that at Kingston you have taken the approach of a health status measurement that really does have a patient focus to it, where one of the measurements is not only patient satisfaction with their life but a measurement of how well they can cope with other aspects of living.

Have you found a difference—I don't know if this measurement has been done—with the personal measurement of a dialysis patient, whether in the self-care or in the hospital unit, from the issues that might be associated with self-analysis of a cancer patient, say, or of an AIDS patient? Are there things that are different in the way people would measure their own health status as they're part of a course of treatment? Did you also find a difference if a person did have, say, a pulmonary illness or a cardiovascular illness as well?

**Dr Singer:** I'm not sure of the first question you're asking. The instrument we're using is a generic instrument, not disease-specific for renal disease. I don't know if this answers your question. The Rand study has a long history in the United States, this instrument development going back probably to the 1970s when they did their health insurance experiment. This instrument is being used mainly in the United States but also now in the UK and parts of Europe for a whole variety of patients with chronic, debilitating diseases. It's really to look at people with chronic illnesses.

What I think is good about is that, as you said, it's a patient report, not of satisfaction, but a patient report of how those patients believe they're functioning and their perceptions of their health. It's been used in patients with HIV, it's been used in patients with arthritis, heart disease etc.

What we're hoping to do, with some people in Ottawa, is to see if we can use this instrument to measure disease burden between groups, if we do a good enough case mix.

**Mrs Sullivan:** That's what I was wondering.

**Dr Singer:** When we first started measuring these, we were pretty astounded that some of our patients were



scoring as low as symptomatic HIV patients when we looked at the literature, although when we talked to the nurses they really weren't surprised; their perception had been that some of these people actually saw themselves as quite ill.

So we've done this type of study, but what we're also trying to do is incorporate this measure in our general care for these patients. We measure their health status quarterly and put these scores on their flowsheets that we use, and when we have patient conferences we use these scores in addition to their biochemical parameters to try to get a better assessment of how the patients are doing. We're trying to involve everyone in the health care team looking after these patients to use these scores rather than their sort of "gut" impression of how the patients are doing.

We've gotten to the stage where people look at the scores, we've gotten to the stage where people begin to use them to assess the patient, but we don't know yet whether they're still going to be valuable for designing intervention specifically for an individual patient. I think it's going to take a few years to know whether that's going to be a useful tool or not.

I don't know if this answers your question. There are a number of disease-specific questionnaires that have been designed for patients with renal disease. We decided to use a generic instrument instead.

**Mrs Sullivan:** That's interesting. Oh, I'm going to get away with another question. Have you discovered any difference in the self-definition if a person does have a co-morbidity?

**Dr Singer:** Do you mean, are they worse if they have a co-morbidity?

**Mrs Sullivan:** Yes, will they identify themselves as being worse.

**Dr Singer:** If you look at the scores and do some a modelling process where you fit in the variables and look at some sort of regression analysis, you'll find that the co-morbidities are negative predictors, so the score will be dragged down by the co-morbidity and obviously by the severity of the co-morbidity. Ischaemic heart disease, peripheral vascular disease, diabetes with complications will give that person a lower score than what they would have achieved had they not had those co-morbidities.

What has really been interesting with these patients is that their mental health scores have been really very good. If I had to predict whether we would need a psychiatrist, let's say, resident in our unit, I would say definitely not. Most of these people are very well psychologically adjusted.

If I had to put our money on a resource person other than the nurses and technical staff, I think it would be social workers and occupational therapists. If we could do little things to make these people's lives a lot easier, in addition to self-care and help them stay within the community, I think that would make the biggest impact.

**Mrs Sullivan:** That was where I was going next. Have you identified any other areas where you don't have the human resources or other resources in place?

**Dr Singer:** Definitely social workers, dietitians and

occupational therapists. I think we're really quite deficient in our resources.

**Mr Jim Wilson:** Can I just tag on to that? In other areas, with the patients in my riding, for example, the number one problem is the physical toll and stress and strain of driving or being driven to the centre. Social workers in my county and the Kidney Foundation and everybody tries to do something to alleviate that and get them volunteer drivers.

**Dr Singer:** You know what's fascinating about the self-care patients? We started measuring these scores while they were training in Kingston to go to Belleville, and there was a delay in opening Belleville, so we had these measured for probably six months before they went to Belleville, and then we followed them for six months after they actually went to Belleville. There was a small enhancement of their scores when they physically relocated, but the great bulk of the difference was already there before they relocated. So it wasn't just the driving; I think it's more than that. If you talk to home haemo patients, it's this control they had. Even when they were training in our unit in Kingston to relocate to Belleville, they still had more control, still had more involvement in their process of care, and there was a camaraderie among the group and much more understanding of the physiology and the whole process of dialysis. I think that's what was responsible for most of their feeling better. There was, as I mentioned, a small enhancement when they physically relocated, so there wasn't the concern about driving, but that didn't explain most of it.

**The Vice-Chair:** Thank you for presentation.

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WILLIAM CLARK

**The Vice-Chair:** The next presenter is Dr William Clark. Thank you, Doctor, for agreeing to have Dr Stiller and Dr Singer precede you.

**Dr William Clark:** What I'd like to do is try to keep you awake for the next 10 minutes, but I'm going to barrage you with a few numbers. I thought I would just give you an overview of the region we actually serve, the southwestern Ontario region, and let you see the number problems we currently have, because I suspect our number problems are very similar to everyone else's—this is going to be a bit repetitive, I'm sure, for many of you—and then briefly allude to some of my beliefs about possible methods of dealing with the shortcomings.

This is the region. As you can see, it's a rather large geographical region, southwestern Ontario. There are about 1.4 million people within this region, and they're serviced by the London health science centre and also the Windsor unit. The London health science centre is a rationalized service with three hospitals, one providing transplantation for the entire region, one providing self-care facilities for the entire region. So there's a satellite unit in Hanover, a satellite self-care unit in Samia and also a satellite self-care unit in London—these are units which don't have physicians on site who actually provide dialysis for patients—as well as in-centre units in London and in Windsor.

In terms of where we fit, if we look at per million in

terms of current end-stage renal failure, we have 601 patients per million population in end-stage renal failure. The Canadian average is about 518, the US average is 661, and, as you can see, Japan is 877. I guess the rising level of affluence—at least, one can correlate end-stage renal failure with economic indicators and they correlate well, in terms of recognition of the problem and treatment.

If we are to look at where we fit in terms of Canada, this is data from 1992 for Canada and this is 1994 for us, so we probably look a little better. Although we may actually have slightly higher numbers per million in terms of the total end-stage renal failure, we transplant more than anyone else in the world as a jurisdiction; we have a greater number of transplants than any other country in the world and any other jurisdiction within this country. We have 300 patients per million who are successfully transplanted, and, as you can see, we have 301 on dialysis. So Dr Stiller, although he has been failing, has been failing reasonably well.

The reason we picked 1990 and 1994 is that in 1990, the ministry did address the problem of dialysis within our region as phase 2 of a three-part program which was trying to deal with the shortfall in treatment for end-stage renal failure. At that time, several of the issues were addressed in our region. I will show you the recommendations of that report, which was projected until 1995, and what has actually happened in our region during that period of time, so that possibly we can get some idea as to where the current problem is.

I must say the ministry has been aware, as I'm sure it has been aware throughout, of the problems we're facing and has tried to address them. The last formal attempt beyond the life support program was in 1990. What you can see is that the percentage of our population has changed: The percentage who have transplants is less, although we're still greater than the Canadian average, and the percentage on dialysis is slightly more, although it's greater in 1994 than 1990, and there's been a marked rise in the number of patients who are on peritoneal dialysis, but we are not at the Canadian average for our region.

In terms of the report, this is the report that was constructed for the ministry by CONSUP, which is an independent agency report, to deal with recommendations about our region in 1990. These were the chief recommendations: We were to actually enhance our in-centre dialysis stations, we were to increase the rate of transplantation, we were to increase the rate of self-care dialysis, and we were also to increase the number of patients on peritoneal dialysis.

If we were to look at what it recommended in 1990—I'll show you what our data are from 1990 to 1994, and you can decide how well we have done. As you can see, we probably have not done that well. We had 51 stations created as of 1990, and there has been no further creation of new stations for in-centre dialysis, so we still have 51. The in-centre population has grown from 202 to 251, which puts us slightly above the optimum, or at the optimum, I guess, for occupancy. We can discuss that, I suppose, briefly.

There has been an increased rate of transplant surgery. There actually hasn't; we have fewer patients now who are transplanted. It's a simplified view to look at transplantation as a success model, because in 10 years you've lost about 40% of those grafts and those patients re-enter the dialysis or end-stage renal failure program again and require further redress. It's a nice simplification to think you can provide a form of therapy and the patient disappears, but in reality that does not occur at the current time, relative to our current technology.

What's actually happened is that as our transplant rate has declined, the failure rate of the patients we have in the transplant pool is exceeding our entry rate into transplantation. There has been a universal, let us say across the western world, major decline in donor availability. This is not peculiar to our constituency; it's peculiar to every constituency in which transplantation occurs. There is a variety of explanations: seatbelt legislation, RIDE programs—the availability of previous donors—the growth of intensive care units. It's a very complex issue. Anyway, the rate is greatly down.

What about self-care modalities? We've had a major increase in self-care from 1990 to 1994, a doubling actually, in patients who are dialysing in self-care centres, out-of-hospital haemodialysis, and we've expanded our peritoneal program, almost tripling it in that time period.

In terms of dealing with the issues we've been able to deal with, we have dealt with the report.

The interesting thing is that when one looks at the report, it estimates where we'll be in 1995, its prediction in 1990. I'll just transpose those numbers so they can be more readily seen. The CONSUP report in 1990 suggested that by 1995 we'd have 705 patients with end-stage renal failure, and actually we have 841. It suggested we would have 402 transplants; we actually have 420. It suggested we would have 303 patients on dialysis; we have 421, and of those, 305 are on haemodialysis.

So you can see we are way ahead of our schedule for 1995, relative to their projection numbers. At the time they projected, we indicated our growth rate was 10%. They took an 8% growth rate, even though we told them at the time that we had always grown, in the previous 10 years, more than 10% per annum. You can see the shortfall that does occur when you do that.

This is just an idea of where patients are in terms of dialysis between 1990 and 1994. There's been a great increase in terms of peritoneal dialysis, self-care dialysis and home dialysis in the patients who are out-of-hospital and being dialysed from 1990 to 1994; as you can see, 77 to 170. But we still have had an increase in in-centre, because we are dialysing an older population with co-morbidity, who have a ischaemic heart disease and diabetic complications that mean in-centre is usually the only choice for these patients. There's a certain reality index we can't escape from.

In terms of our current annualized growth rate, we are growing at about 12.5% per annum in terms of the dialysis population. The majority of this is in out-of-hospital dialysis, which is in the more efficient, cheaper methods that give the patients a greater sense of independence and I think probably a greater sense of wellbeing



and, probably, productivity in society.

Our current occupancy rate is five. You can have six patients per station in an in-centre haemodialysis unit. That means you would have no capacity to deal with acute renal failure and the other exigencies which occur in an in-hospital centre. As one of our hospitals, which I belong to, is a major trauma centre, we use at least one in six slots just to treat acute renal failure. That's not included in these numbers, but we use the personnel and the equipment to provide for that service as well.

If we're to look at the problem in terms of why there's a shortfall and why we haven't dealt with the growth—the ministry has provided a program to deal with growth, called the life support funding program, and here's why I think it doesn't work. Here's a perfect example. Here's our budget from 1992-93 for our institution, and what you can see is that cardiovascular surgery, unfortunately, didn't fulfil its quota. We all have quotas we fulfil and actually exceed, and we get more funding.

The problem with this formula is that it occurs a year after you've done things. You've got to deal with the growth in the first year and then you get the money the year later, but the money is levered against other programs. The life support programs are: cardiovascular surgery, intraocular lens implants—I'm not sure why that's a life support facility, but there you go—end-stage renal disease, TPN, neonatal intensive care, oncology chemotherapy, and hip and knee replacements are also life support.

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Anyway, these programs generate numbers. As you can see, our program, the dialysis program, generated a major increase in activity. It had, I think, about a \$584,000 expectation to deal with that growth in the previous year. We needed more machines, we needed nurses, we needed social workers, dieticians, pharmacists, in other words, parts of these people. We needed the funding for them to deal with this expansion.

As you can see, because the cardiovascular program was down, they netted out against our program and therefore we received \$200,000 less. Then, because the ministry had a formula proration at 87%, that was reduced again. Then in terms of where we got within the institution net, we were netted out against each program that was a plus, so we received about half of the funding for the growth we'd already had.

As you can see, this formula doesn't work but it is the current, the only way of growth. It's better than having no formula, and I certainly would say that, but it will never work, it will never address growth in an appropriate fashion, but that's clearly what goes on. It is an attempt, but I don't think it will work.

I think if we were to say, how can we address the problems, obviously it would be nice for us to change society to have answers to transplant everyone, to have a perfect formula for maintaining the transplant, for not requiring dialysis facilities etc, but I think, although those things are wonderful, at the present they're not currently tenable.

What is tenable is that we need an accurate, ongoing

patient registry. We don't have one. We need to know what's on the waiting list, what we can expect, how we can plan for each region so we can do this sensibly.

We do know that in the last 10 years, from looking at our own data, there's a 40% spontaneous generation rate of patients; in other words, the patients are not being followed by the centre, they appear in end-stage renal failure and we have to provide treatment for them. I think that's pretty well the same as the American data which have tried to look at that problem.

The growth funding designated directly to specific programs would help a tremendous amount. In other words, if we designate the money, we don't lever it, as it is currently done, against other programs, because if you have growth and you don't fund it, then you essentially can't deal—you have to ration out your treatment in the following year.

We need really a consensus conference so we can get the people who want to express their beliefs about what's the optimal ratio of patients for dialysis stations, what's the optimal ratio of patients who should be treated in this particular constituency. We need to look at the methods to increase organ availability, because there's no doubt that we are facing a major shortfall just like the rest of the western world and we need to address that. Hopefully, a consensus conference could deal with those issues.

Unlike Dr Stiller and Dr Singer, if I had to place my money someplace in terms of where it's not being placed right now, I would place it in trying to prevent people from getting into renal failure. I think that, yes, transplantation is a very efficient and cheap method, but a cheaper method yet is to prevent people from getting there.

Certainly there have been major advances in the last 10 years in certain areas and this has required research funding and, as Dr Stiller indicates, we need to invest in this area. I think it's an important area and it's not being adequately invested in at all.

The two changes that have occurred in the diabetic population are the realization that ACE inhibitor therapy can reduce the decline in renal function and the realization that protein restriction can also decrease the decline in the DCCT study.

Three major studies have indicated ways of reducing the dialysis patients entering end-stage renal therapy from diabetes. I would suspect that if we looked at the changes we should see a 50% reduction in 10 years' time in those patients entering end-stage renal failure programs, and they are the current majority.

Research into preventive disease will actually have some impact, but we need to look at other avenues in that area as well and, really, the funding is not very extensive in that area at all. It's actually minimal.

The other thing I would just recommend briefly as a little plug is, this is the way we organize our renal administrative program at our own unit. We're actually going to do this in the London region itself, so that we include patients as well as patient coordinators and the kidney foundation representatives on the committee. We



meet on a monthly basis to discuss the shortfalls in the program and how to plan for them, what kind of equipment we need, what is the best etc, how we can improve the conditions of the patients in the unit. We've had the opportunity to actually have access to these individuals and we found it a very useful way.

Certainly, if one was to direct funding, one might recommend that we develop units which are responsive to the local programs, that actually that is their major focus and that they do have patient input and input from the kidney foundation, so there would be an appropriate balance.

**Mrs Sullivan:** I thought that, first of all, the information you provided us with respect to the projections done four years ago and the actuality in terms of case load and treatment modalities was very interesting. I want to go back over those figures.

In the meantime, when you mention the life-support funding and looking at the deficiencies in the existing funding system, has there been or has anyone put forward a disease-specific funding formula that would eliminate that kind of competitive nature for funding within a specialty hospital, whether it's disease-specific or program-specific?

**Dr Clark:** I must say, I'm not aware of that. I'm sure that some of the people from the ministry would be more familiar because I'm sure they've gone over this. I'm sure they're aware that this formula doesn't work.

This is an attempt to rationally deal with the problem of how you provide economic resources to units that compete with one another for those resources. Obviously the answer is there's never enough, so they've attempted to try to lever the program. The reality, though, with end-stage renal failure is that we aren't falsifying the data. The people are there.

We are lower than the US, we are lower than Japan, we are lower than Switzerland, we are higher than other countries, and it probably does reflect to a large extent our level of affluence as a nation in terms of providing restrictions within the life-support funding, how much is there. But I think really, if we're going to say that we are going to deal with this problem rationally over a long period of time, the long-term solution is obviously research and prevention of the numbers going into end-stage renal failure. I think that may be achievable over the next 20 years.

The short-term solutions are obviously to improve the rate of transplantation and to have a mature and adjusted formula for funding programs directly rather than to try to have the physician ration sort of implicitly by saying, "We're not going to give you the funding for this," so you start to drop your age ranges, you start to become disease-specific, you start to do things that are not appropriate or right.

But when the resources are limited, you don't have—at the end of the spectrum, you're forced to make those decisions. As I think was indicated, it's an unpleasant method of dealing with health care. And I think a lot of physicians are not very interested in doing that. They would rather bring the system to its knees in a bankrupt

fashion than to implicitly ration.

**Mrs Sullivan:** You mentioned the need for emphasis on preventive research. Are there any prevention programs in place now and how are they evaluated?

**Dr Clark:** There have been no economic incentives for prevention programs. Individual physicians and groups are obviously doing their own preventive treatment with their patient programs, but there has been no formalized addressing of this. I suspect that if you look throughout the province, there will be wide disparities in accessibility and types of therapy. But the knowledge is available.

**Mrs Sullivan:** Is this one area that ICES is looking at, do you know?

**Dr Clark:** I don't know if ICES is looking at it. It would be interesting if they did. I think David Naylor could do a very interesting study on this.

**Mr Jim Wilson:** On that latter point, I was thinking it probably should be one of the recommendations of this committee, to get Dr Naylor to look at it.

Dr Clark, thank you for your presentation. Can we go back to your penultimate overhead there? I had two questions: First of all, I guess to research, if you don't mind, could we get a copy of the 1990 CONSUP report that Dr Clark referred to for southwestern Ontario? That's one I haven't read.

**Dr Clark:** It is available, actually. I'm sorry, I should have brought it.

1700

**Mr Jim Wilson:** They'll grab it for us, I think. Bob is great at performing miracles at the last minute.

**Dr Clark:** Is this what you wanted?

**Mr Jim Wilson:** Yes, that's it: 40% spontaneous generation. I know you gave a brief explanation but I kind of missed it in my mind. What does that mean?

**Dr Clark:** What happens really is that in programs where we follow patients for up to 10 years before they enter an end-stage renal failure modality, you think you're seeing the bulk, but still, we've looked at our last 10 years and we find that 40% of the patients appeared spontaneously—in other words, unbeknownst to the nephrologist—requiring end-stage renal therapy within a month or so. Even with planning, we're going to have a problem with spontaneous generation, although I suspect that part of that is an educational phenomenon too at the level of family physicians and the widespread geographical area that we serve, although I suspect Toronto may have the same numbers.

**Mr Jim Wilson:** It seems to me 40% is pretty high to be thrust upon the system from time to time.

**Dr Clark:** It is. It happens every year, and we anticipate it. But yes, if we had preventive programs, I suspect that number would decline. We don't have formalized programs that, say, are involved in prevention, but I think with time that will change.

**Mr Jim Wilson:** Life-support program: Can you give me a better feel for—I understand how you sort of end up with 50-cent dollars, or almost 50-cent dollars. I understand the mathematics of it. But the leveraging that

goes on, are you specifically told by administrators as the year goes on—I need this simplified—somebody's over budget, somebody's under budget, "You're getting over budget"? How does it work?

**Dr Clark:** Basically, with the renal administrative committee that we do have, we meet with them every month and they tell us any problems they're having in terms of funding. They immediately try to pass on any economic difficulties, which is understandable, to us, to let us know where we're going.

They indicated to us this year that they hadn't received the life-support funding and their projection was that because they were falling short in the cardiovascular, we would probably only get 50%. So somehow or other we had to make other savings or changes in our program to fund it.

**Mr Jim Wilson:** How does that translate in layman's terms on the patients you see? Are they denied treatment? Is treatment delayed?

**Dr Clark:** I think what we do is we seek to provide the cheapest method of treatment. It may not be the most appropriate for that individual but it's the difference between surviving and not surviving. As you get pushed down economically, your choices are a little more difficult.

You can't say, "Gosh, it would be nice for these patients, because they have ischaemic heart disease, they're diabetic and they're 75, that they should be on an in-centre haemodialysis program," because they're not going to do very well with PD. But no, we will do that, or encourage them to self-care. In other words—

**Mr Jim Wilson:** You try to find them something.

**Dr Clark:** We will try to find them something that's cheaper.

**Mr Jim Wilson:** Even if it's not the most appropriate for them.

**Dr Clark:** Even if it isn't the most appropriate. I think the most appropriate treatment is the one that patients choose themselves, because they are the best judge of their own sense of what they wish to do and what they can do. I think that has been found repeatedly.

**Mr Jim Wilson:** Just one other very quick question. In all of this, you talked about your occupancy rate being five. Do you have any room for travellers, any travellers' clinic?

**Dr Clark:** The one in six is where we have room for the traveller and where we have the room for the acute renal failure. But our acute renal failure burden—

**Mr Jim Wilson:** Is high.

**Dr Clark:** —is high. Actually, I think we have slightly more trauma in our region. I'm not sure why. Maybe the 401 curve wasn't built properly near our community.

**Mr Jim Wilson:** I won't touch that.

**Dr Clark:** But we do have a higher trauma rate than the rest of the province. So we're busy using that one in six for acute renal failure.

Yes, we can accommodate people from other centres, but it is with decreasing frequency and ability that we can

do that, through time. But we will try because we think it's very important to try to improve the quality of life of these people who suffer from end-stage renal failure, and it is nice for them to have some mobility occasionally to travel to other centres.

**Mr Wessenger:** Thank you very much for your presentation. I was interested in your comment when you said that the patients do get treatment but not necessarily the most ideal type of dialysis. I'd just like to follow that up because I understand in other jurisdictions—for example, peritoneal dialysis is much more popular in the Scandinavian countries and northern Europe than it is in North America. Do you think that is not a medical choice, or do you think that is an economic choice?

**Dr Clark:** I think it depends on the country and it depends upon the enthusiasm and the experience of the centre. There are a lot of variables. Toronto probably has the highest PD rate in the world, I would think, and that probably represents economic decisions as well as some major enthusiasm and early planning for that as a major modality.

Who has the best selection? I think the centre that canvasses its patient population and asks them if they are getting the treatment that they desire and that is best for their quality of life has the best mix.

**Mr Wessenger:** Right. So basically you're indicating that in your area the patients are not necessarily getting their treatment of choice.

**Dr Clark:** I think it's becoming more difficult for that to occur. I think there has been an attempt by the ministry to address this, but we obviously need another attempt right now.

**Mr Wessenger:** Right. If I might just follow up one other point you made, you indicated you felt that in the longer term we should be able to reduce the level of haemodialysis and peritoneal dialysis in future as a result of prevention measures. You indicated about a 10-year time frame. Is that what you—

**Dr Clark:** I think realistically we're looking at a 10-year time frame. If you're looking at intervening with diabetes and making a major impact, you have to understand that for the diabetic, it's a mean time of about 18 years for him to get the diabetes and to end up in end-stage renal failure. Now, the other part of the corollary, the age-onset diabetic, probably may suffer a similar course, although it's less well studied.

We're going to have to look at the studies in the insulin-requiring diabetic and see if they will reflect in the non-insulin-requiring diabetic. There's some suspicion that they will, and I would think if you intervene, you're looking at probably a 10-year time period before you're going to see a major impact.

I think each year you're going to have an increasing impact in terms of reduction in entry, which is really tremendous, because the diabetic population has created an epidemic in the United States and the rest of the western world about end-stage renal failure facilities. That has been a major add-in in the last 10 years that wasn't there before.

Yes, it's providing a quality of survival for these



patients, but if it could be avoided, I think it would certainly be desirable for those people in terms of the quality of life.

**The Vice-Chair:** Thank you for your presentation, Dr Clark. Mr Gardner would like to speak for a moment about his summary.

**Dr Bob Gardner:** Members will see that I've given another addition to the summary of testimony. This includes the witnesses from yesterday. I wouldn't normally do that. It's a fairly rough version of it—I haven't yet seen the Hansard, of course—but there were some new ideas from yesterday, and witnesses did address some of the issues that members have been concerned with, quite clearly. I wanted to get that in your hands as you consider your instructions to me for the report.

You'll see that the new material from yesterday in the summary is shaded. The other thing that the clerk is going to hand out now is a series of questions that members may consider, again in giving instructions to me on the report, so if you could look at them and consider that.

Finally, Mr Wilson asked me to find out some information on the situation in British Columbia and Nova Scotia. I understand that Ms Abbey will also be telling us about that issue. I did speak to the coordinators in both provinces and I do have information. Perhaps I'll wait until we have her testimony and then I can add any additional stuff that I got today. I didn't have a chance to write that up. I can do that tomorrow for members.

**Mr Jim Wilson:** If I may just a comment for a minute, I want to thank Mr Gardner for extremely prompt attention to his reporting to this committee. I appreciate that.

I think the agreement—I just want to check with you, Mr Chairman, and with the clerk—is that on Monday we have an informal meeting to go over the report and talk with research, and again next Tuesday. Can we just get that clarified, what was decided in the subcommittee?

**The Vice-Chair:** Could you confirm that?

**Clerk of the Committee (Mr Doug Arnott):** I understood from the Chair that he was expecting the full committee would meet again next Tuesday, and that on Monday there would be a subcommittee meeting if required.

**Mr Jim Wilson:** I thought Monday we were going to look at sort of a preliminary draft of a report. Have I got that wrong?

**Mr Wessenger:** If I might just give my recollection here, my recollection was that there would be a meeting at 3:30 on Monday of the subcommittee at which other members could be present, and we would informally look at the report. That was my understanding.

**Mr Jim Wilson:** Oh, okay. Fine. I think you're right, Mr Wessenger. I have to leave at 5:20 to go to a crime task force, so I want to tell Ms Abbey that I appreciate her presenting this, and Dr Churchill, and I'll be sure to catch the Hansards.

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**Dr Gardner:** Again, if I may, the only thing I would

say on the Monday schedule is that I can do whatever members wish by Monday but, on the other hand, members have not yet indicated what they want in the report. I can put together the obvious stuff, but that won't be your comments on what you've heard from witnesses and your recommendations. That may be what you wish to do on Monday, is have that be when you'll first kick that around. That's fine by me. But in terms of what you want me to be doing between now and then, I will need some further instruction.

**The Vice-Chair:** Fine. Thank you for your report.

DAVID CHURCHILL

**The Vice-Chair:** The next presentation will be made by Dr Churchill. Could you come forward, please, introduce yourself and proceed with your presentation when you're ready. Welcome.

**Dr David Churchill:** I'm David Churchill and I'm the director of the division of nephrology at McMaster University. I know it's been a long afternoon and I'll attempt to be brief and perhaps spend more time responding to questions.

The regional nephrology program at St Joseph's supplies end-stage renal failure care for about 1.2 million people. Our dialysis services include hospital-based haemodialysis, self-care, home haemodialysis and peritoneal dialysis. We also supply the transplant backup for the dialysis units at St Catharines and Kitchener-Waterloo.

In our own hospital we have 20 stations in our hospital haemodialysis unit. We operate six days a week, 7 in the morning till almost midnight. Each of the machines, as Dr Clark has indicated, can treat six patients per week or three patients per day.

What I thought I would do to start off would be to give a snapshot of what happened last Monday. We have a capacity for treating 60 patients and we treated 67 patients on that day. The way we were able to do that was to open up an infection control area that's usually reserved for patients with dangerous infections and treat three patients there. We also opened an isolated station that had poor nursing monitoring. We had actually abandoned it, but we had to reopen that. We also had to take a machine to a patient's room and have one-on-one nursing, plus another treatment in an intensive care unit. So we treated 67 patients when we have an official capacity of 60.

On top of that, we had two more requests that same day for dialysis. One was a 56-year-old lady who had complications of cancer chemotherapy and the other was a request from Brantford to dialyse an 89-year-old gentleman who's one of these 40% who just appear. Fortunately, the lady with the cancer-induced renal failure had a spontaneous recovery and the elderly gentleman decided not to have dialysis.

If one or both of those patients had required dialysis—rationing isn't tomorrow, rationing would have been that day, and it wouldn't have been explicit; we would have been rationing as physicians and as an institution and finding some way to explain away to relatives why we couldn't treat that particular patient. So rationing is here



and we do have a problem. The planning's on a day-to-day basis and we're very frightened of what's going to happen the next day.

I've attached to the back and labelled table 1 an outline of what has happened at St Joseph's Hospital since 1981. These are data from the Canadian Organ Replacement Register. If you look at the very first line, under "Dialysis Units," you can see that our hospital haemodialysis population has grown from 47 patients to 111. The home haemodialysis program has shrunk; it's gone from 39 down to 13 patients. It's a very small program at this time. Our self-care haemodialysis group has increased from 18 to 60 patients.

Overall, our haemodialysis population has increased from 104 patients in 1981 to 184 patients in 1993. If you look at the second subtotal, titled "Total PD," the total peritoneal dialysis population has gone from 60 to 95. Finally, we have our total dialysis population, which has grown from 164 to 279 patients over this time.

There are a couple of alarming trends. If you look at "New Patients" and follow the line along from 1981, you can see 52, 59, 57, so stable at 50 to 60 new patients per year. Then, in 1991, we have an incredible increase which we thought was a fluke, but we increase to 90 new patients per year, and it has been stable at 90 new patients per year. The early results in 1994 suggest it'll be at least that, if not more.

As far as transplants are concerned, if you look just below the shaded line towards the bottom, you can see the number of transplants performed. In 1981 it was 22. We quickly went up to about 40, and it has stayed stable at 40 transplants per year. Of even greater concern is that we had 20 patients last year who returned to dialysis, having failed transplant. The net gain from transplantation in our area was only 20 patients, despite the fact that we're taking in 90 new patients per year. We have a real problem.

The next thing we did was to say, how are we going to deal with this? What is the future going to hold for us in Hamilton-Wentworth and the surrounding areas? What we did was to get demographic data on the referral population in terms of its age structure. From that one can estimate, based on age-specific rates of renal failure, the renal failure rate for that group. We also have age-specific death rates. We have entry into the program and we have exit from the program. Transplantation is not going to be very much of a net gain.

By doing that, we are able to calculate, using conservative data, that we would probably plateau at about 380 patients at the end of 1996. We have to find some way of treating a net increase of an additional 100 patients over the next three years, and transplantation's not the answer to that growth.

As far as transplantation is concerned, I think Dr Stiller has spoken very eloquently about transplantation. I have little to add, although I'm far more optimistic about presumed consent than he is.

The other thing that we have done and have been not pioneers but certainly leaders in the area in Canada is that we have an aggressive program of transplanting from

living, emotionally related donors, from spouses. Probably half of our living donors next door will be non-related living donors, and it's a very aggressive and a very emotionally trying process.

The other thing that's curious, and Dr Stiller alluded to it, is that recently the central tariff committee of the OMA has made recommendations about changes in the fee structure. One of the fees that they have recommended reducing is the fee for medical supervision of renal transplantation, and it really flies in the face of reality that one should provide incentives rather than disincentives for what is truly a cost-effective program.

Let me focus more on dialysis because that's where I spend most of my time. As some of the questioners have indicated, there are two basic forms of dialysis: haemodialysis and peritoneal dialysis. Basically there is no difference in survival between these two major types of dialysis.

As far as quality of life is concerned, there have been many studies done addressing quality of life and there is in fact no difference in quality of life once one adjusts for co-morbid conditions between these various dialysis modalities. On the other hand, transplantation is clearly a treatment which provides a much superior quality of life.

We did a fully allocated costing analysis of costs at St Joseph's Hospital in 1990, and these data are currently under review at the *Annals of Internal Medicine*. The data that we have I've listed on page 6. It indicates that the most cost-effective modality by far is home haemodialysis, a modality that is shrinking in terms of its utilization.

CAPD, or peritoneal dialysis, costs about \$33,000 in our hospital, self-care haemodialysis \$42,000 and hospital haemodialysis is by far and away the most expensive, at \$57,000 per patient per year. In our program we try very hard to have people on home dialysis therapies that are more cost-effective, but yet we still have 43% of our patients on hospital haemodialysis.

As far as home haemodialysis is concerned, it has declined. There have been a number of reasons for it. One reason is that our patient mix is different. We have a lot of older patients with more illness and they're not stable enough to be at home. The second reason is that many of the patients who would have gone on home haemodialysis are now on home peritoneal dialysis. A third reason is that many people are unwilling to take a machine into their home—it brings the illness into their home—and have elected to go with self-care dialysis, which can be done in a non-hospital facility.

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Another problem has been that we've been unable to get capital funding to buy new and modern haemodialysis units for the home haemodialysis program. What was happening was that we had the cheapest machines and the least effective membranes in the home. Most of us felt that our best and most highly motivated patients should not be exposed to the least efficient form of technology. I think that's something we can change.

The other thing that we've done is try to broaden the

criteria for self-care dialysis. Initially patients had to be able to do everything for themselves in a manner similar to home haemodialysis patients. We then realized we could have some patients who needed a little bit more help, and they were called limited care patients. Then we had other patients who wouldn't do anything or couldn't do anything for themselves but were very stable.

What we did was we lumped them altogether and we called the new unit the progressive care unit. We have a spectrum of care, from total care for stable patients all the way over to true self-care dialysis. That worked pretty well and we increased our numbers, and this was in an out-of-hospital site.

Our next problem was we had some people who were able to go to this unit and who were stable and yet would come into the haemodialysis unit and say: "There is no way I'm going to give consent to go elsewhere. It's nice here. I have lots of nurses taking care of me. I refuse to sign the consent."

What we did then was to move our progressive care dialysis unit back into the hospital, in an area which simulates an out-of-hospital environment, and now that constraint no longer exists. We simply say, "You are allocated for treatment to area B," which is our progressive care unit, which is far more cost-effective because we have fewer staff there. We've worked very, very hard at doing that.

CAPD is a very cost-effective modality as well. The problem is there's a very high failure rate. I've just indicated at the bottom of page 7 that we perhaps should consider looking more seriously at cyclical therapy, which may improve the success rate, albeit at a cost which is somewhat higher than CAPD, but certainly a lot lower than the cost of transferring that patient back to hospital-based haemodialysis.

On the last page I've listed a number of specific recommendations, which are obviously personal opinions.

The first is that kidney transplantation is the most cost-effective form of treatment and should be encouraged. But I think to feel that one can transplant oneself out of the dialysis dilemma is really deluding oneself. It's not the answer to the dialysis problem. We should encourage it, we should be very aggressive about it, but the dialysis problem will not go away.

Legislation regarding presumed consent must be seriously considered, and I think it would increase the supply of cadaver kidneys.

I think the recommendations from committees such as the OMA tariff committee which introduce a disincentive for cost-effective treatment should be reviewed, but I'm not sure exactly who should review them. They appear to be responsible to very few people.

I agree with Dr Clark that strategic planning for dialysis services should be on a regional basis. We've tried, in a very amateurish way, to get all of southwestern Ontario together to do that, but we really need a secretariat and a way of managing this.

Another practice which hasn't been touched upon deals with the life support. Some hospitals cap their dialysis programs and they say, "Enough's enough. We've spent

all our money," and even though patients are supposed to be dialysed in their regions, they then become a burden on other hospitals that haven't capped their programs. It's a very sore point.

I think we should have a special funding mechanism for home haemodialysis equipment which is outside the hospital funding. I think we should look at developing these progressive care dialysis units because I think it will allow us to deal with the growth of dialysis.

Finally, if the demand for dialysis treatment is greater than the resources, and rationalization has to be dealt with, then this has to be an explicit, open process with full responsibility taken by society, whether it's by the government being the proxy for society or whatever. But it has to be open. It cannot be implicit; it cannot be forced on physicians or individual hospitals. Thank you very much for your time.

**The Vice-Chair:** Thank you. Mr Waters.

**Mr Daniel Waters (Muskoka-Georgian Bay):** I was going to actually ask Mr Clark and then he got away on me. I'm going to ask you because you brought up again this 40% of people—you brought it up in a different way. I forget how many people showed all of a sudden in that one graph. In the one chart you jumped from 62 to 93 in one year. Then in the body you say that you have done some planning for 1996. What happens if next year you have another jump?

I guess I'm wondering, this 40% of people or whatever the percentage is in your case, how do we get a handle on that? Is it people who are slipping through the system, people who are in the system and who are not detecting the problem early enough so that we can plan for it? There's got to be something. In your case, when you get talking about that number of people, I was curious where it came from. You said you tried to track them. Were they people who came into your community? Were they people who were always in the community? What was the story?

**Dr Churchill:** Your question has several parts. First of all, whether there were 60 people who appeared in a given year or 90 people who appeared in a given year, 60% of those people were known to us before they appeared on dialysis; 40% were not known. So, for each year we have 60% known, 40% unknown.

The reason for that is that the symptoms of kidney failure are very, very subtle. In other words, the symptoms are not related to kidneys. People are a little tired, they're a little anaemic, and the sensitivity to making the diagnosis early is not high among the practising physicians.

Just this morning before I came, a lady with 10% kidney function was referred. I'm seeing her tomorrow and I've never heard of her before. This happens all the time. There's nothing much we can do about it except to better educate the primary care physicians to be sensitive to the symptoms and make the diagnosis earlier, and then we can plan, because it's costly when we have people turn up in our emergency rooms.

As far as the jump from the 60 to 90 is concerned, I really don't know what happened that year. Obviously,



the age structure of our population didn't change. Perhaps the physicians became more sensitive and recognized more patients. I don't have an explanation for that step jump at all.

**Mr Waters:** My concern is that it was a reality. This is my first day on this committee and you're the second person I've heard talk about this. I know that when I sit and talk with my caucus members, and we hear a lot of discussion in the House as well, about planning, how do we plan for this if out of the blue, all of a sudden you jumped to that extent in one year, that number of people?

If we don't know where they came from within the group, how can we plan for the future? Obviously, unless we do something about, I don't know, whether it's diet or something way back down the line—this is a growth industry that we don't want to see grow.

**Dr Churchill:** It really is very difficult to answer your question. There are a lot of things I can speculate about. For instance, several years ago we would have turned away or discouraged people referring octogenarians. We see people in their 80s all the time now. The family doctors may very well have allowed people in their 80s to die from kidney failure and now they say, "Oh, the technology's available"—and quite rightly—"and this person is bright and alert, and just because they're 80 years old they shouldn't be denied dialysis." That sort of jump may be responsible—in other words, there may have been a change in the way that we deal with the pre-existing renal failure.

The data that I showed you are based on age-related rates of renal failure and the population structure in our referral area and the predicted change in demographics from the department of geography. If the rate of renal failure changes or if people start referring more people, then these estimates may be an underestimate.

1730

**Mr Waters:** If I might, just one quick question. I would like you to expand maybe a bit on—somewhere in the body of this—the home dialysis. In here there's a comment that they were dealing with the older machines. What do you suggest we do? I'd like you to expand a bit on that. I think it's worthwhile.

**Dr Churchill:** In our hospital, we tend not to be as tied into life support which is targeted specifically at patients with renal failure or patients with cardiac problems. The life support moneys—they may be 50 cents on the dollar and they may be late—are taken into the hospital's global budget and they aren't earmarked for program A or program B.

We have convinced our administration, and it's an administration which understands the problem, that home haemodialysis is a priority. They have allocated additional capital funding from within the hospital budget. We are in the process of converting all of our home haemodialysis patients from old machines to modern technology. We are encouraging new patients to go on home haemodialysis and they will have the modern technology.

**Mr Larry O'Connor (Durham-York):** Part of I guess why we're dealing with this is because of the

changes and trying to be more responsive to the needs of people in the community who would like to have some home care as a preferred option, as opposed to travelling great distances.

Some of what we heard through the presentation, some of the affected families too, is the huge cost. I guess there's a range in how some of that home delivery of service is provided. Some bring in registered nurses to perform the functions that are necessary; it doesn't necessarily need to be a registered nurse, though. How do we try to develop a network out there that can provide the service but maybe not at such a high cost to the family?

I think part of it's going to be an education process so that the family can feel comfortable, that a family member can actually be the one who's doing that portion that they've got a registered nurse doing. Just some of your comments on that.

**Dr Churchill:** For patients who live somewhat distant from the centre and might require an hour, an hour and a half to drive, we encourage those patients to learn home haemodialysis, with the patients themselves being responsible for the treatment. They have control, as Dr Singer mentioned, and that's very, very important. Home haemodialysis and CAPD are the preferred options.

We have a smaller number of patients who are not capable of performing the home dialysis treatments themselves and we have developed a program known as a home helper program for the peritoneal dialysis program. It consists of using a cyclist at home, and the nurses who deal with this are VON nurses. The VON nurse goes into the home late in the evening, attaches the patient to the dialysis machine and another nurse takes him off in the morning. It's a very cost-effective way of doing things. If the machine alarms in the middle of the night, they're instructed: "Simply turn it off. We'll deal with it in the morning." That deals with another group of patients.

Another option is an option which we haven't exercised but is very common in Alberta, and that is to have satellite units which have very minimal health care professional staffing. The patients don't have the dialysis machines in their home, but share several dialysis machines perhaps in the local small hospital. A person, not necessarily a professional, is employed to provide an extra pair of hands to help them get off and on the machine. That, in Alberta, is a very cost-effective way of doing things, but it's not a program that's been exercised very much in Ontario.

**The Vice-Chair:** Thank you.

**Mr O'Connor:** What—

**The Vice-Chair:** I'm sorry. We're extremely short of time. We have another presenter who is an hour late in presenting and there's going to be a vote in the House, I was told.

**Mr O'Connor:** I appreciate that.

**The Vice-Chair:** Ms Sullivan, a short question.

**Mrs Sullivan:** The family physician has been raised on several occasions through the hearings with respect to a number of areas, one of which is possibly a prediction



that our rates are lower than American rates because there is a lack of referral. Another area was with respect to educating the family practitioner so that the doctor can come forward with an earlier diagnosis. We've heard a bit, but frankly not an awful lot, about the family physician's role in longer-term care and involvement with the patient after the dialysis has begun.

It seems to me that one of the things that people who have mentioned the family physician have pointed out is a shortcoming in physician education. I guess the other area too was the family physician dealing with the donor request. I'm wondering what recommendations you would make with respect to increasing the knowledge of the family physician; what perhaps relationship, say, the specialty groups have with the family physician research unit in London that's doing a fair amount of work. What happens? How does this whole gang of people get together?

**Dr Churchill:** As far as the patients who are already on dialysis are concerned, the family doctors who have patients on dialysis learn very quickly about end-stage renal failure and dialysis and they become sensitized and are good practitioners. They actually take care of the patients between dialysis visits. We encourage that. Those physicians do a very good job. They recognize the next patient who comes in with kidney failure.

But despite the fact that kidney failure has a tremendous impact on individuals and on the health care system, many physicians just don't have patients with kidney failure in their practice. They're just not accustomed to it. And the things that you don't see very often you don't think about very much.

I'd like to have some magic solution for improving the education so that nobody would ever miss a patient with chronic renal failure. I think we're going to have to live with doing our best with including this on refresher days for family doctors, but it's, quite frankly, quite low on people's priority list. If they haven't seen a patient with kidney failure in five years of practice, they don't think it's important.

**The Vice-Chair:** Thank you for your presentation. It would be nice to spend more time, I know. We need to.

NANCY ABBEY

**The Vice-Chair:** The next presenter is Nancy Abbey. Welcome. Sorry that we're an hour late hearing you.

**Ms Nancy Abbey:** What time does everybody have to leave by?

**The Vice-Chair:** I understand there's a vote in the House. I was told. But welcome.

**Ms Abbey:** Let's hope they've saved the best for last.

Good afternoon. I also want to thank the chairman and the committee for having the chance to come and talk to you today. Some of you may not know, but Baxter Corp is the largest dialysis supplier in Canada. We supply dialysis products to over 2,700 home clients. We are a peritoneal as well as a haemodialysis supplier. Our head office is in Mississauga. We're about 1,500 employees and we manufacture our peritoneal dialysis supplies in Alliston.

My primary responsibilities at Baxter as business

development manager include strategic planning for the renal division as well as developing new services for our dialysis customers. We consider our customers both our home clients as well as customers in the hospital.

After sitting through the hearings the past couple of days, there seemed to be a need to understand how dialysis is funded in Ontario, as well as understanding some of the initiatives that are taking place in other provinces. My role in strategic planning has caused me to travel across this country and understand on a provincial basis what has happened in health care reform and also to understand how some of those changes have impacted dialysis services.

There are two parts to my talk. The first part is to discuss with you how dialysis is funded in Ontario and the second part is to briefly mention a pilot project that Baxter is willing to fund which will enhance the care of home PD patients.

#### 1740

As Dr Clark pointed out this afternoon, dialysis is considered a life support program. It's recognized as a high-growth area and is funded on a per-patient basis, ranging from about \$27,000 for a PD patient to about \$40,000 for a total care haemodialysis patient. Dr Clark went through with you the programs that are funded under life support, and this includes dialysis.

To give you a perspective on how this all began, the life support program for dialysis was established by the Ministry of Health in 1986. You'll find this in your handout.

In 1986, standard costs for renal services were developed by three hospitals: Kingston General, London University and Ottawa General. They looked at direct cost categories: nursing, medical and surgical supplies, some drugs, lab supplies, X-ray and there were some other costs and other items included. A variable overhead rate of 17% was added in, but costs for capital equipment were not included.

There are two components to this funding method, component one and component two. Component one really looks at what your projected forecast will be in growth of patients, and again, it is on a per patient basis. Component two then matches what your projected growth is to what you actually had happen, so you have a readjusted base. Component one really is reflective—and Dr Clark went through this—it's an after-the-fact. You have the growth and then you get the dollars afterwards.

To make this concept a little easier to understand, I've listed here three life support funding treatments for dialysis. There's a more complete listing in your handout, but I think it's important to understand the concept.

Every type of dialysis treatment has a weighted unit to it. This is reflected by the actual intensity of the direct cost categories. There's also the unit value. This is the component of life support that changes every year. What I've done so we can compare apples to apples is, haemodialysis is typically 156 treatments a year per patient, so we're looking at it on an annualized basis here.

Haemodialysis is funded per treatment, whereas home therapies are funded on an annual basis. So you'll see

that there's quite a bit of difference here between what is given for each new total care haemodialysis patient who is projected to come into a program versus what's given for a home PD maintenance.

You'll note that the numbers I show were for 1992-93. The reason for this is that I didn't have an update for 1993-94, but I do understand through the comments that have been made throughout these hearings that funding has now been given for 1993-94 patient growth and that the ministry is committed to funding dialysis on a volume basis for 1994-95, with the actual dollar amount still to be determined.

In theory, this funding of dialysis should work relatively well, but I think we've heard what some of the downfalls are. The major problem is that there aren't measurement tools in place to make sure that what the hospital receives actually to fund its dialysis growth is then allocated to the dialysis budget. This obviously puts strains on it because the programs have accepted those patients into their program, but it's difficult to get the dollars to reflect that growth.

I just want to go into some examples. I'm now going into some of the other initiatives that have occurred across the country and how dialysis is funded a little differently. On the overhead here, I'm not very familiar with the Yukon and the Northwest Territories, unfortunately, but the green areas, the midwest as well as the Atlantic provinces, primarily are funded on a global basis. The hospital receives money in its operating budget and the dialysis budgets compete with all the other budgets in the hospital.

The areas in red, primarily BC, Ontario and Nova Scotia, have all different types of funding mechanisms. British Columbia has a program where they've looked at their home dialysis program and it's managed through a government agency called Kidney Dialysis Service. They've taken all the dollars that would be allocated to home patients and centralized the budget. The hospitals receive money for in-centre care, including home patient training. It's a very cost-effective way to do it, and I'll talk about that a little bit in a minute.

Ontario is red because of our life support program.

Nova Scotia has also developed a different funding program. I've included a handout, and in the interest of time I'm obviously not going to have a chance to go into any great detail, but it's a handout from the Royal College meeting in September. Dr Jindal is the director of the nephrology program at Victoria General Hospital and was very much involved in Nova Scotia in developing a provincial dialysis program.

The key elements of the handout: Basically there was a multidisciplinary government committee established to review the dialysis program for both Nova Scotia and Prince Edward Island. PEI does not offer haemodialysis on the island. Patients receive that care in Nova Scotia.

The funding here is that, if you look at the second column, the top, under "Funding":

"The review revealed that a failure to increase funding and staffing of the program would result in overt rationing of dialysis beyond our current conservative approach

to patients with major co-morbidity."

What they've done now is taken the dollars out of the hospital budgets, developed a provincial dialysis budget, and they have different budget envelopes. They have an administrative budget. They have a unified budget for provincial home dialysis, similar to what British Columbia has done. They have a province-wide capital equipment budget for haemo machines as well as cyclers. The in-centre haemo unit is funded in their hospital budgets on a real-cost-per-procedure basis.

Basically, the review process has confirmed that the government is committed to funding dialysis. They recommend the dollars that are allocated to dialysis. That there's no new money in the system means some other service has to suffer because of it.

I think it's an interesting approach, and it was very much built around the success that the Kidney Dialysis Service had in British Columbia.

The other point is around new initiatives to deal with the dialysis crisis. Since 1991, British Columbia has had a BC Renal Disease Council. This is something that Mr Gardner made reference to earlier. I've included for you the terms of reference of what this BC renal council was established for.

Its purpose was to act as an advisory body, and it facilitated the provision of high-quality accessible care to renal patients throughout the province through the coordination of a network of health care services. It was a multidisciplinary committee and it reported to the Deputy Minister of Health, although it's just changed. There's a new leader for this renal council, and it's now the executive director of community health.

Their functions included developing a long-term strategic plan. They established task forces to do this. They're developing guidelines, they're providing recommendations, and I think it's been a success story. It took a while to get this committee going. I think there were lots of different people involved and the results weren't coming. Their initial project, being a costing project, has been a big success and it's going to allow them to plan in the future with some of the issues we've talked about here. Specifically, one of the ideas they have is having a registry of all patients who would potentially need dialysis care and developing that, having their postal codes and being able to map it and understanding where these patients are coming from.

You'll recall that I mentioned my presentation was in two parts. Mindful of the role we play within the dialysis community and supporting our customers, I'd like to advise this committee that in the next couple of weeks we'll be bringing to the Minister of Health a proposal for a possible pilot project. This project is a not-for-profit, Baxter-funded initiative which will offer support services for home dialysis patients. I'm happy to note that Dr Clark mentioned in his talk that a preventive-type clinic was a good idea and I believe this centre will fit in nicely with that idea.

Overall, I commend the government, and specifically Jim Wilson, for encouraging these hearings. It's been an excellent opportunity for the issues to be brought forward



in a thorough and thoughtful manner.

With the financial constraints being faced by the ministry, we sincerely hope that we will have the chance to review this proposal with the minister. I think it's time for some creative initiatives to be tried. Our intention is to have an outline of this proposal to all the committee members within the next couple of days, with the formal proposal being completed in a couple of weeks and presented to the minister.

The other point that I'll touch on real briefly is this talk about, how do you educate GPs? One of the initiatives we're doing some research on is the idea of doing video teleconferencing education. There are a multitude of satellite hookups that are actually quite rural-community-based that we might be able to leverage. It's certainly a Baxter initiative and we'll be looking at it for our 1995 budget. The chances here are great to be able to have a speaker perhaps located in Toronto but the ability to do a general education on what renal failure is and when you refer patients, and I think the result of that could be very interesting and very productive.

1750

**The Vice-Chair:** Thank you. Questions?

**Mrs Sullivan:** I'm interested that just towards the end you spoke about I guess a pre-dialysis patient database, which clearly is missing. I'm just wondering if you would just note in the notes that we may want to discuss that, as well as a network approach between centres. Dr Churchill, I think, spoke not of an agency but of a regional approach to planning. My sense from presenters when they've discussed an organizational approach is that an independent agency is not appropriate in kidney disease but perhaps a BC model would be, which is a network of networks. Is that your sense?

**Ms Abbey:** I think it's important, when you've got a chronic care program in an acute care facility and the growth—you know, the 10% statistic is quoted over and over again. The trouble is, that acute care budget is being driven down at the same time as your chronic care is growing. The volume-funded bit of the budget works. The problem is, it's lumped in with these other programs, and so the net effect is that dialysis suffers.

I think the other comment about the ongoing regional planning is so critical to this. We reach these crises and then we get into planning, rather than just continuing the planning so that we don't get into these crises.

Perhaps, as Dr Churchill alluded to, maybe rather than—in BC most of the care is delivered at the urban area. In Nova Scotia it's one hospital. So it's a little easier to have one dialysis budget. The notion of maybe having regional dialysis budgets to cater to the services being provided in the dialysis units per region would be an interesting concept to see how it would work.

**Mr O'Connor:** As we've gone through this set of committee hearings, we've had the opportunity to talk to a number of people involved in future planning, and the concerns. I think one thing I might have asked the good doctor who was before you would have been a question on planning. There's the education part that's got to take place for the doctors, the physicians, earlier on. There's

also then the planning that needs to take place, for example, the planning that's taking place right now that's just being set up that we heard from the committee chair who came before us.

How do we make sure that all of those parts get tied into it? As we look towards planning, and the educating that's necessary too to be part of that planning, do you have any suggestions how we can tie that together a little bit and direct it? I'm sure that all the comments made in these committee hearings will be looked at by that committee.

**Ms Abbey:** Right. I think we've got a great opportunity with so many planning groups and committees established. We've heard from the Central East Regional Dialysis Committee, which has a six-month mandate to develop a report. We're looking at sort of the end of 1994 to have a look at that. The Kidney Foundation: I work with them on their PD working group, and I think it's been an excellent example of different people, a multidisciplinary approach to looking at developing some standards around care, and I also think the report coming from this committee.

I guess what I would be encouraged to see is that that planning then turns into implementation. The challenge is going to be, from those plans, you're going to see that more dollars are needed, and that's going to be a real ministry concern. Where are those dollars going to come from?

**Mr O'Connor:** I think part of the hearing process will also point out, and we've heard ourselves, that what has been based as only the high-tech end of things isn't the only choice that is there, and I guess there's some education for the consumers too that needs to take place, which is part of an overall picture as well. I think these committee hearings do help in that a wee bit as well.

**Ms Abbey:** I think everyone has quoted that home dialysis is the least expensive, and I think it's important not to get caught up on what you hear is the total cost for an in-centre haemo patient. You're going to always see different numbers depending on the model that someone used, what they included, what they didn't include.

I think it's important that whoever has looked at those costs maintain a consistent model on how they looked at all their therapies, and then the relative difference between the therapies is consistent. You'll have CAPD as a cost-effective alternative to both total care and self-care haemodialysis. That's consistent regardless of who's looked at the costs.

**Mrs Sullivan:** I have a supplementary on this. We did indeed have a presentation last Tuesday, I believe, from an independent health facility with respect to cost comparisons: hospital-based, home-based and IHF-based. I was, I think you recall, a little suspicious of the numbers that were put forward, because I was concerned that in fact they reflect the same reality and that the independent health facility may well be dealing with a more stable patient than certainly the hospital-based haemo or the assisted self-care.

I understand that Baxter has done some documentation that provides an equivalency in the cost comparisons.



Could you make that available to the committee, or is that protected information?

**Ms Abbey:** No, it's not. In fact, you've seen it quoted, and I know you've seen a number of presentations.

**Mrs Sullivan:** I know.

**Ms Abbey:** Dr Mendelssohn alluded to it, because his article in the CMA Journal references that cost analysis, and Dr deVeber showed it yesterday.

The key point there is the number of patients.

I think around the self-care the unfortunate thing is, there are so many different versions of self-care, and it's really, what is the nurse doing for the patient? If you have a self-care unit in a hospital where you have access to more nursing, then you may have called a patient self-care, but in fact they aren't really doing self-care.

When it's an alternate-site facility and you don't have the resources there, that referral for which patients are actually capable of doing self-care at an alternate site—those patients do have to be stable, and they are going to be less expensive because of the labour component. You can treat more patients with the same number of nurses.

**Mr O'Connor:** One thing that was pointed out to us as well was that there are parts of the process right now that—we're not reusing some of the canisters, I think it

was, that we could be. I just wondered, as somebody representing the manufacturers, what your view is on that. Is it a possibility? It seemed to point to some possible savings there. It was pointed out to us as a potential.

**Ms Abbey:** Our position on that: Our dialysers are manufactured and labelled as single-use products. The FDA in the US would like us to go through extensive testing to show that our dialysers could be reused. We do not have any control over the quality that's done in the reuse process, so we can only guarantee our dialysers from a quality standpoint for the first time they're used.

I think there are cost savings associated with it, but I think you have to look at what those cost savings are relative to other things you can do in your program to try and save the same amount of dollars.

In the US, if we were to change the labelling on the dialysers, any manufacturer would suffer in terms of the cost to get that multi-use label. That's a very difficult thing and it's extremely expensive.

**The Vice-Chair:** Thank you for your presentation. I'm pleased to note that you've had the full complement of time even though we were an hour late getting to you. The committee stands adjourned, to meet again, I believe, on Tuesday at 3:30. Thank you for your attendance.

The committee adjourned at 1759.







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